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UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

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| Misty Blanchette Porter | ) | |
| | ) | |
| v. | ) | Case No. 2:17-cv-194 |
| | ) | |
| Dartmouth-Hitchcock Medical Center, et al. | ) | |
| | ) | |

RE: Day 10 of Jury Trial

DATE: April 4, 2025

LOCATION: Burlington, Vermont

BEFORE: Honorable Kevin J. Doyle
Magistrate Judge

**APPEARANCES**:

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(The hearing began at 9:08 a.m.)

THE COURT: Okay. Good morning. Okay. I understand that there might be couple of issues to take up.

ATTORNEY SCHROEDER: I asked Your Honor to just briefly discuss our case in chief. We've got these two witnesses this morning. I think we'll be done fairly quickly, I suspect, and then defendants will rest. We'd like the opportunity to be heard on a motion for directed verdict at that time, but we'd also like to be heard before any rebuttal evidence is put on to discuss that issue as well.

THE COURT: Okay. So maybe during the break, do you think, to discuss scope of the rebuttal? Do you think, to the extent you can anticipate, your witnesses this morning will probably take us to roughly 10:00 o'clock or thereabouts?

ATTORNEY SCHROEDER: I think that's fair, yes.

THE COURT: So then maybe I propose that you finish with your two witness and, even if the break is a little earlier than usual, I think that's okay. And we can take up the issues you've just mentioned at that time.

ATTORNEY SCHROEDER: That would be ideal. Thank you.

THE COURT: Okay. Anything from the plaintiff?

ATTORNEY JONES: Nothing from us.

THE COURT: Okay. Bring in the jury then.

(The Jury enters the courtroom.)

COURTROOM DEPUTY: Your Honor, the matter before the

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Court is Civil Case Number 17-cv-194, Misty Blanchette Porter versus Dartmouth-Hitchcock Medical Center, et al. Present on behalf of the plaintiff are Attorneys Geoffrey Vitt, Eric Jones, and Sarah Nunan. Present on behalf of the defendants are Attorneys Tristram Coffin, Morgan McDonald, and Donald Schroeder. We are here for day ten of a jury trial.

THE COURT: Okay. Good morning, members of the jury. Since you left here yesterday, have you spoken to anyone about the case, or have you learned anything about the case other than what has been presented in court? Okay. Seeing no hands raised, the defendants may call their next witnesses.

ATTORNEY SCHROEDER: Thank you, Your Honor. Defendants call Dr. Jocelyn Chertoff, if I may bring her in.

THE COURT: Yes.

JOCELYN CHERTOFF,

having been duly sworn to tell the truth,

testifies as follows:

THE COURT: Okay. Go ahead, Mr. Schroeder.

DIRECT EXAMINATION BY ATTORNEY SCHROEDER

Q. Thank you, Your Honor. Good morning, Dr. Chertoff. Where do you currently reside?

A. It's not a simple question, but I currently reside primarily in Hanover, New Hampshire, but I am spending long periods of time now on the West Coast as well.

Q. And earlier -- do you have a residence in Portland,

Oregon?
A. Yes, I do.
Q. And were you there earlier this week?
A. Yes, I was.
Q. And did you have difficulty making it from Portland, Oregon to lovely Burlington, Vermont?
A. Yes. I sat on the tarmac through two of my flights being canceled and ultimately spent the night in Chicago.
Q. Wednesday going into Thursday?
A. That was --
Q. Today's Friday.
A. Yes.
Q. Okay, thank you. Could you briefly describe, from high school on, your educational background?
A. I went to the Bronx High School of Science. Then I went to Brown University. I went to University of Vermont College of Medicine for medical school. I went to Hartford Hospital and UCONN for 18 months of internship and then did two years in a physician shortage area in upper New York state. I worked at two different jobs waiting for my residency. So I worked here in Vermont as the medical director for Vermont Emergency Medical Services in what we used to call a "doc in the box" or urgent care center. Then I started my residency at University of Vermont in radiology, and I did a fellowship in body imaging at University of Vermont.

Q. Okay. After all that schooling, did you become employed at some point by Dartmouth-Hitchcock Medical Center, Dartmouth Health, as it's called now?
A. Yes, I finished my fellowship in 1991, and I moved to Hanover to begin my job at Dartmouth-Hitchcock Medical Center.
Q. When was that?
A. 1991.
Q. And then how long were you employed by Dartmouth Health as a physician?
A. I retired in 2023, December 2023. I was at Dartmouth that entire time.
Q. Roughly -- this is lawyer math -- about 32 years?
A. I think it might be 33, but, yes, roughly.
Q. Sorry to shortchange you on that.
A. That's okay. 32 and a half.
Q. And, during that entire time that you were employed by Dartmouth Health, were you employed in the radiology department of Dartmouth Health?
A. Yes.
Q. When you came on, did you assume the head of any particular part of radiology?
A. Yes. When I came on, I was head of gastrointestinal radiology.
Q. And, in terms of radiology and -- oh, what is the radiology department? What are the services? Just briefly,

quick overview for the jury's sake, quick overview of what the radiology department, what the services are performed by the radiology department physicians.

A. Okay. So we do all kinds of imaging, different modalities. We use the word modality to refer essentially to the machines. So, when we look at what we do, we think about it in terms of parts of the body and in terms of the imaging modality. So we do -- x-rays are plain films; fluoroscopy is a kind of dynamic plain film where you can watch what's happening; ultrasound; CAT scan; MRI; nuclear medicine, which involves the administration of radioactive material for imaging. We do interventional radiology, which is an area that concentrates largely on different procedures that are done percutaneously, in other words, through the skin or sometimes through the vascular system where we might inject dyes or put instruments into where we do biopsies.

But, anyway, we do a whole variety of procedures. We also do procedures in other sections. Frequently, ultrasound is used for the procedures, but sometimes it's fluoroscopy or even CT or MR. I'm just trying to think if I've forgotten anything.

When we talk about neuroradiology, we use all of those different modalities in order to image the nervous system, so the brain and spine. So, in some cases, we refer primarily to the body system, like when I say gastrointestinal or body imaging, and, in some cases, we refer primarily to the

modality. So, for example, you might staff ultrasound and look at a lot of different body parts.
Q. And, in terms of the parts of the body generally speaking that you focus on in the radiology department and specifically on the topic of ultrasound, what parts of the body are you, do you generally focus on?
A. So in the department we look at everything, but in ultrasound we are primarily, but not entirely, looking at the lung bases through the pelvis. Now, we do some work particularly now on the extremities, but a great deal of the routine work is in the abdomen and pelvis.
Q. And would that include gynecological ultrasounds?
A. Yes.
Q. Okay. I just want to ask you about some of the positions you have held in the radiology department. You became, when you joined, you were the head of gastrointestinal radiology?
A. Yes.
Q. And did you, and did you have a dual appointment?
A. Yes. I had an appointment in radiology, and I had a secondary appointment in obstetrics and gynecology.
Q. Would that be considered a dual appointment?
A. Yes.
Q. And, given Dartmouth Health's status as an academic center, academic medical center, was it common for physicians to have dual appointments?

A. Yes.
Q. And you were there a little bit over, almost 33 years. Did you, at some point, assume a management role in the radiology department?
A. Yes. Do you want me to describe some of them?
Q. Sure. Just the titles first, and then we'll get in a little bit more detail.
A. So in the radiology department I was program director for the residency program for 17 years. There was a, there was a period, and I don't remember the dates, where I was vice chair. There was only, at that point, one vice chair, and that was starting around 2004. At a later date, there were five vice chairs, and I became one of the vice chairs. I then became interim chair, and ultimately I was chair of the department.
Q. Chair of the radiology department?
A. Correct.
Q. How long were you chair of the radiology department?
A. I think I started in 2015, so about eight years.
Q. And you held that title as chair of the radiology department from roughly 2015 to 2023?
A. Yes.
Q. When you started way back when in 1991, how many radiologists were there at Dartmouth Health?
A. I'm guessing about ten.
Q. Okay. When, and this is just an estimate. I'm not trying

to get a hard number necessarily. When you left in 2023, how many radiologists were employed within the radiology department?

A. Somewhere in the range of 50 to 60.

Q. Okay. So, over the years, it had grown in numbers, correct?

A. Correct.

Q. And it also grew in numbers during the time that you were chair of the department, correct?

A. Correct.

Q. I want to ask you just briefly about your responsibilities as chair of the radiology department. Did you have any responsibilities as chair of the radiology department for hiring?

A. Yes.

Q. Did that include hiring physicians?

A. Yes.

Q. Did you have any responsibilities with respect to the academic mission of the radiology department?

A. Yes.

Q. Did you have any responsibilities for the budget?

A. Yes.

Q. Was there a separate budget for the radiology department?

A. Yes.

Q. Okay. Did you have any responsibilities for residents,

fellows, and physicians within the radiology department?
A. Yes.
Q. And, during -- I just want to ask about specifically ultrasounds and the area of gynecological ultrasounds and early obstetric ultrasounds. Are radiology physicians within the radiology department skilled in handling and performing or reviewing ultrasounds -- I'm not sure what the right word is here -- in the area of gynecological ultrasounds and early obstetric ultrasounds?
A. I would say the correct word is interpreting and reporting, and, yes, we are all trained in our residency to read or interpret gynecologic and early OB ultrasound, and part of our responsibility when we are staffing in ultrasound, staffing meaning working in ultrasound, our responsibilities include gynecologic and early OB ultrasound.
Q. And, in terms of interpreting, to use your phrase, ultrasounds, does, do the radiology physicians, including yourself, regularly perform interpretations of ultrasounds, gynecological or early obstetric?
A. Yes.
Q. And does that happen in the normal course?
A. Yes.
Q. On a daily basis?
A. Yes.
Q. As chair of the department, do you regularly assess the

staffing needs of your department?
A. Yes.
Q. And I want to go back to -- do you know the plaintiff in this case?
A. I do.
Q. And the plaintiff in this case is Dr. Misty Blanchette Porter. Did you have any interaction with her while she was employed at Dartmouth Health?
A. Yes.
Q. Was it regular?
A. I would say --
Q. Minimal?
A. -- regularly irregular. I didn't see her every day, but I saw her frequently.
Q. Okay. And do you know if she had a dual appointment in OB/GYN and radiology?
A. I think she did.
Q. Okay. In 2017 you were you aware of the closure of the REI division?
A. Do you mean before it closed or at the time it closed?
Q. Well, let's start with before it closed.
A. Immediately before.
Q. Okay. You were informed about that?
A. I was informed.
Q. Okay. And do you recall Leslie DeMars -- who is Leslie

DeMars?
A. Leslie DeMars was the chair of OB/GYN.
Q. And, in May of 2017, she was the chair of the OB/GYN, correct?
A. I don't have those dates. I assume you're correct.
Q. Okay. Do you recall Leslie DeMars coming to you to inquire as to whether you might have an available position for Dr. Porter in some kind of capacity for gynecological ultrasounds?
A. I recall her coming to tell me that the REI division was closing, and I have a somewhat vague, but real, recollection of her asking whether I could hire Dr. Porter.
Q. Okay. And, in asking you about hiring Dr. Porter, did you have an understanding of the subspecialty of ultrasounds that Dr. Porter had expertise in?
A. Yes.
Q. And what was that?
A. Gynecologic, especially, well, general gynecologic ultrasound, absolutely. Particular expertise in REI ultrasound as it refers, as it relates to REI and early OB ultrasound.
Q. Okay. And did you, at that point in roughly the May 2017 time period, before that period and after that period, did you perform gynecologic ultrasounds and early obstetric ultrasounds?
A. I would say interpret. Occasionally, I performed but --

Q. I'm sorry. Interpret, yes.
A. The reason I make the distinction is that performing means actually holding the probe and doing the entire scan, and generally it was too busy in ultrasound for me or any of the other providers to spend the time with each patient performing each scan. We had six rooms all coming to us for interpretation. So we had techs in each room performing. The images would come to us. The tech would review it with us, and we would go in and scan if there was a question.
Q. Just to check to determine how to interpret the ultrasound if you needed further clarification?
A. Correct.
Q. And, in terms of who performed the ultrasound, the actual doing of the ultrasound, that would be done by the ultrasound techs?
A. Largely, yes.
Q. Okay. And, in terms of interpreting gynecologic ultrasounds and early obstetric ultrasounds, did you and other members of the radiology department, before May 2017 and after May 2017, perform, interpret those types of ultrasounds on a regular basis?
A. Yes. I still do on a per diem basis. I still work there occasionally on a per diem basis.
Q. Okay. And that would include gynecologic ultrasounds and early obstetric ultrasounds as well as other parts of the body?

A. Yes.
Q. Okay. In that time period when the REI division was closed and you had this conversation with Dr. DeMars, do you recall what your response was to her at that point as to whether or not the radiology department had the need for somebody with Dr. Porter's subspecialty expertise in either a part-time or full-time basis?
A. Yes, I do.
Q. What did you say? What was your response?
A. That I did not have a position for somebody to do only GYN and early OB ultrasound.
Q. Okay. If you brought somebody in -- and I want to just ask so that the jury can understand how you staff for ultrasounds and how you did staff for ultrasounds. Take your time. I don't want you to --
A. Okay.
Q. In terms of staffing for ultrasounds, why would it be a challenge or not necessary to have somebody that just did a subspecialty of ultrasounds on a routine basis?
A. So the way we staff in ultrasound, I think, in 2017 we may have only had four or five rooms, but, at this point, we have six. We have, we have techs in each room that are scanning a series of patients. The patients that go into each room, really, it has mostly to do with the machine and, you know, what the machine is particularly good for.

But, over the course, when I -- as soon as we start in the morning, the techs start maybe a half an hour before we start. So they perform their first scans, and, as soon as you walk in, there are scans to be interpreted. The techs wait, take turns, essentially, talking to the attending, and the attending is the radiologist. Review their findings, including whatever history they may have gotten from the patient, and I, as the provider, check the images, make sure I have no questions.

If there's time, I redictate and sign it on the spot. If there's another tech waiting, I make notes, and the next tech comes and shows me their case. So, throughout the day with a break in the middle of the day, there are multiple rooms essentially feeding cases one after the other to the interpreting physician.

Q. And are they, in terms of the ultrasounds that the radiologist that is assigned that day to interpret ultrasounds, are they for a variety of different body parts?

A. Yes, they're for, not only a variety of different body parts, but they come from different locations. So, in between the regularly scheduled cases, there are cases from the emergency room, from the clinics that may have varying degrees of urgency or suspected urgency.

Q. Okay. So, if you had somebody that was only performing gynecologic ultrasounds or early obstetric ultrasounds, how would that impact your staffing and schedule of other

radiologists in the radiology department?
A. Well, you would have to -- I would have had to staff two physicians at a time, one being the one who was doing only the GYN and early OB and the other doing all of the other cases. And, if the OB/GYN reader were not available for any reason, then the person, the other person, would have to read, would read all of those cases as well.
Q. Do you typically have one -- sorry to interrupt, but do you typically have one radiologist on to handle all the ultrasounds at once?
A. Yes.
Q. So this would require having two radiologists on at work at the same time, if, if you considered having somebody that had a subspecialty in ultrasound?
A. Yes.
Q. Okay. Did you have a business need for that at that point in 2017?
A. I did not think that I had a business need for that at that time, no.
Q. And have you ever hired anybody or moved anybody into the radiology department to do just a specific subset of ultrasounds for the radiology department?
A. No. I have, at times, particularly later in the last few years when things became very subspecialized, certain exams might go to a radiologist in a different part of the department

who was very subspecialized, for example, in musculoskeletal ultrasound. But, no, I have never hired someone only to do a subset of ultrasound with no other responsibilities in the department.

Q. And was there any need back when Dr. DeMars approached you to have somebody in either a part-time or full-time basis to do gynecologic or early obstetric ultrasounds only?

A. I did not believe that I had a need for someone to do that at that time, no.

Q. And you were in charge of all staffing for the radiology department, correct?

A. Correct.

ATTORNEY SCHROEDER: Just give me one second, Your Honor.

THE COURT: Yes.

ATTORNEY SCHROEDER: I don't have any further questions at this point, but plaintiff's counsel may have some questions.

THE COURT: Okay. Cross-examination?

CROSS-EXAMINATION BY ATTORNEY NUNAN

Q. Good morning, Dr. Chertoff.

A. Good morning.

Q. I'm Sarah Nunan. I'm the attorney for Dr. Porter. Who is Emily Baker?

A. Emily Baker is a MFM, or a maternal fetal medicine,

physician in OB/GYN.
Q. And how long has she been there?
A. I don't know how long she's been there. She's been there a long time.
Q. Long time, yeah. And was she the division director for a long time?
A. I think so.
Q. Okay. Were you aware that Emily Baker wrote to Maria Padin in May of 2017 and said, "We have now lost GYN ultrasound. The radiology department is no substitute. The residents will not get GYN ultrasound training. We cannot do SHGs"?
A. No, I was not aware of that. SHGs are not done under ultrasound, though.
Q. Are they not done in the radiology department, or are they not done with ultrasound?
A. They are done in the radiology department, but they are not done with ultrasound.
Q. Okay.
A. Oh, actually, there's two different procedures. There's a sonohysterogram which is done under ultrasound, and then there's the hysterosalpingogram which is not done under ultrasound.
Q. Is that a HyCoSy, a procedure called a HyCoSy?
A. I don't know what a HyCoSy is.

Q. You don't?
A. No. But, yeah, I think SHG stands sono -- I'm sorry. It was done under ultrasound.
Q. Got it. Are you aware that HyCoSy and SHGs were the kind of procedures that Dr. Porter was performing?
A. I don't know what a HyCoSy is, so no.
Q. Okay. Were you aware that SHGs were the type of procedure that Dr. Porter was performing?
A. As I recall, I don't recall it being exclusively something that Dr. Porter did. I assume she did them, as other people did as well, but I don't remember that she was ever the only person doing them, but I may be wrong there.
Q. If Emily Baker is reporting in May of 2017, "We cannot do SHGs", you don't have reason to doubt her?
A. Well, actually, I do, because my recollection is that other people did SHGs, I believe, and we interpreted the results. But I'm not questioning Emily's assessment at that time.
Q. Okay. Do you know who Joan Barthold is?
A. Yes.
Q. Okay. Are you aware that, in the summer of 2017, she called Dr.Porter and asked her to walk her through an ultrasound procedure over the phone?
ATTORNEY SCHROEDER: Objection, hearsay and beyond the scope.

THE COURT: I'll allow it.
THE WITNESS: I'm not aware of that.
BY ATTORNEY NUNAN:
Q. Okay. This was after Dr. Porter had been fired.
A. Again, I'm not aware of it before or after or during. I'm not aware of it.
Q. Okay. I noted in your testimony that you said that the ultrasounds were largely performed by the ultrasound techs, correct?
ATTORNEY SCHROEDER: Objection.
THE COURT: Well, she's asking about her prior testimony.
ATTORNEY SCHROEDER: Yes, I know. Mischaracterizes the testimony, performed the ultrasound --
THE COURT: Okay, okay. So then you can ask the question, and Dr. Chertoff can answer according to her recollection.
BY ATTORNEY NUNAN:
Q. Okay. Was it common that the ultrasound techs performed the actual imaging and then they were read by a doctor in the reading room; is that correct? Is that my understanding of your testimony?
A. Yes.
Q. Okay. But that, occasionally, there would be someone who was a doctor, not the tech, performing the scan, right?

A. Correct.
Q. Okay. And were you aware that one of the benefits of Dr. Porter's practice was the fact that she was the one often doing the ultrasound?
A. Well, I think you're actually asking me two questions. One is, Was it a benefit? And one is, Was I aware that she was performing the scans? I was aware that, at times, she was performing the scans.
Q. Okay. And the benefit to that would be that the patient doesn't have to come in and have the scan and then come back for an appointment for the interpretation, correct?
A. No, that's not correct. The patient does not come back in for an appointment for the interpretation.
Q. Okay. So were you aware that Dr. Porter was able to do the scan, read it, and do a biopsy all in one appointment?
A. I'm just thinking about whether I was aware of that. Certainly, she would be able to do that.
Q. All right.
A. I wasn't aware she was doing biopsies --
(Simultaneous speaking.)
THE COURT: Please let her. Let's let the Witness answer the question before you pose the next question, please.
ATTORNEY SCHROEDER: Thank you.
ATTORNEY NUNAN: Great. Just a second, please.
THE COURT: Yes.

ATTORNEY NUNAN: That's all the questions I have for you. Thank you.

THE COURT: Any redirect, Mr. Schroeder? I'm asking Mr. Schroeder if he has any redirect.

ATTORNEY SCHROEDER: Very briefly, Your Honor.

THE COURT: Okay.

REDIRECT EXAMINATION ATTORNEY SCHROEDER

Q. Dr. Chertoff, did you, on occasion, perform the actual ultrasound scan?

A. Yes.

Q. And did that happen in the regular course of you being the chair of the radiology department and a member of the department?

A. Well, so, throughout my time as a resident, as a fellow, and as an attending physician, there were times when I performed an ultrasound examination with my own hand, yes.

Q. Okay. And are you aware, as the chair of the radiology department, whether other physicians in the radiology department performed ultrasound scans from time to time?

A. Yes, they did.

Q. Okay. Really quick estimate or approximation. You were employed at Dartmouth Health for almost 33 years, right? You have to verbalize your answer. So almost 33 years there, right?

THE COURT: So what is the answer to the question?

THE WITNESS: Wait. What's the question?
BY ATTORNEY SCHROEDER:
Q. I just said -- you were just nodding your head. You have to verbalize.
A. I'm sorry. Yes, I was employed there for something in the range of 33 years, yes.
Q. Throughout your employment, if you had to estimate, how many gynecologic ultrasounds or early obstetric ultrasounds -- we'll put it in that wider group -- do you think --
A. Yes.
Q. -- you've interpreted throughout your career?
A. So a complete back-of-the-napkin guess, and I think that this would be possibly an understatement based on some quick math, at least 10,000.
Q. 10,000 ultrasounds?
A. Just of early OB and GYN, yes.
ATTORNEY SCHROEDER: Thank you. Thank you, Your Honor.
THE COURT: Any recross?
RECROSS-EXAMINATION ATTORNEY NUNAN
Q. Were you aware that it was the routine practice of the generalists in the OB/GYN department to take their radiology readings and run them by Dr. Porter?
A. When you say regular practice, I'm not sure what you mean, if you mean every time. But, no, I'm not -- I was not aware

that it was a general practice for them to have our cases reread.

Q. Were you aware that there was often a line at Dr. Porter's door for people to get their ultrasounds read by her?

A. I was not, never in the vicinity of Dr. Porter's door.

ATTORNEY NUNAN: That's all the questions I have. Thank you.

THE COURT: Okay. You may step down, Dr. Chertoff. Thank you.

ATTORNEY SCHROEDER: If I may, Your Honor, escort her out and bring our next witness, Dr. Maria Padin?

THE COURT: Yes.

MARIA PADIN,

having been duly sworn to tell the truth,

testifies as follows:

THE COURT: Please go ahead.

ATTORNEY SCHROEDER: May I proceed, Your Honor?

THE COURT: Yes.

DIRECT EXAMINATION BY ATTORNEY SCHROEDER

Q. Good morning, Dr. Padin.

A. Good morning.

Q. Welcome back. I want to ask you to just briefly describe your educational background.

A. I went to undergrad in California and did a bachelors in language and literature, and then I went to medical school at

Dartmouth, and, following that, I did my residency at Maine Medical Center in obstetrics and gynecology.

Q. Okay. Where did you grow up?

A. I grew up between New York and Puerto Rico.

Q. Okay. And how did that come about?

A. I call it the Puerto Rican Diaspora. We went back and forth, as many other families did during that time. And I was born in New York, but then we moved to Puerto Rico, and then, when I was about five or six, I became ill, and my family moved to New York so I could get medical care.

Q. Did that experience somehow spawn a desire to enter the field of medicine?

A. Absolutely.

Q. Okay. Do you have any kids?

A. Four.

Q. Any grandkids?

A. Nine.

Q. Congratulations.

A. Thank you.

Q. Currently, where are you employed?

A. I'm employed at Dartmouth. I work in the southern part of the state. As an obstetrician and a gynecologist, I still see patients, but primarily the preponderance of my role now is managing the various clinics for Dartmouth in the southern part.

Q. Southern part of New Hampshire?
A. Correct.
Q. And, in terms of your -- what's your title?
A. I'm the chief medical officer for the southern region community group practices.
Q. Okay. Is that CGP?
A. That's CGP.
Q. And what does that entail, so that the jury understands what exactly the scope of your duties are as a CMO?
A. So we have 13 sites, 90 clinics, 398 providers, over 1,200 staff members. We provide a full range of services from pediatric care, primary care, surgical specialties, OB/GYN, across all of the different clinics, three major sites, and we also have a perioperative space, meaning an ambulatory surgical center.
Q. Okay. And you said 13 sites, 1,200 staff members. How many clinics?
A. 90 clinics.
Q. 90?
A. 90 clinics.
Q. And, are you, as the CMO, ultimately responsible for the daily operation of all of those parts of the Dartmouth Health system?
A. In conjunction with my chief operating officer.
Q. Who is that?

A. Craig Beck.
Q. And do you still do clinical work as a generalist in the OB/GYN department?
A. Correct.
Q. And when did you become the CMO?
A. I became the CMO for the southern practices in 2020. Prior to that, I was the CMO at the medical center, and I became the CMO at the medical center in the late fall of 2015.
Q. So, between 2015 and 2020, you were the CMO at the medical center in Lebanon, New Hampshire?
A. That's correct.
Q. And then after that in 2020 you became the CMO for the southern region of New Hampshire?
A. The week that Covid was announced, yes. I still remember that.
Q. I'm sure you do.
A. I do.
Q. So no shortage of responsibilities as a result of that, I assume.
A. Not a day off for several months, yeah.
Q. So, with respect to the emphasis on or your assumption of the role in the southern part of New Hampshire, what was the reason for that at Dartmouth Health? Why was there a need for you to be handling issues in the southern part of New Hampshire?

A. So we have a fairly broad clinical delivery system in the south, and we are an organization that really values physician leadership. So part of it was really there had been a transition of a medical director at that time that was a regional medical director, and our medical staff was growing in the south. So there was a desire to change the role to a CMO role. And we were also, at that time, expanding our clinical services to include a surgical site, and, having been at the medical center and also, as a GYN, being familiar with the surgical environment, I was asked if I would consider taking or interviewing for that role.

Q. Okay. And you were promoted into that role, correct?

A. Yes.

Q. Okay. And you have held, you've held that role since that time, correct?

A. Correct.

Q. And, with respect to -- and who do you report to?

A. So I report to Joanne Conroy. I also report to Dr. Edward Merrens.

Q. And, despite being in the role of a CMO, you've continued to be a generalist in the OB/GYN department?

A. Correct.

Q. And you continue to provide clinical services in the OB/GYN department?

A. Yes.

Q. And is your specialty within that obstetrics, or is it another, or just generalist?
A. So a generalist has both components, meaning that a generalist is someone who has privileges to do obstetrical care, which is caring for pregnant women, not only during pregnancy, but also assessing and caring for conditions that may impact pregnancy and, of course, managing labor and delivery and the postpartum period. So that's one part of a generalist's job.

The other part of the generalist's job is managing the care of women's health needs as it relates to gynecological issues or illnesses or diseases that may impact their reproduction.
Q. And, with respect to your privileges, what's the difference between, say, privileges in one particular area and obstetric privileges for OB/GYN?
A. So people can have various levels of privileges, but, as a generalist, you have both, meaning that you can cover labor and delivery and you can also do GYN care. There are, for example, people who focus mostly on the obstetrical care of patients and disease conditions that impact pregnant mothers. Those are maternal fetal medicine doctors, for example. There are individuals who focus on GYN oncology, meaning cancer in women that are gynecological in origin. Those individuals tend not to do both things.

So a generalist can do all of those things to a certain level, and, but again, a GYN oncologist would not be doing obstetrical deliveries because that's not what they do every day, and a MFM would not be covering, for example, the emergency room when a gynecological emergency arose.

Q. So, with respect to being a generalist, the privileges are as a generalist, correct?

A. Correct.

Q. And those privileges allow you then to do obstetrics and also handle matters involving gynecological health care?

A. Correct.

Q. Okay. And have you maintained those privileges throughout the last ten years?

A. I have maintained all of my privileges throughout the last ten years. I will say that, in the last year, I have not done obstetrics, so I probably will not maintain those privileges in the next recredentialing cycle.

Q. Okay. But, in terms of your privileges during, say, the 2015 to 2020 time timeframe, did you maintain your generalist privileges in OB/GYN?

A. I maintained all of my obstetrical privileges.

Q. Okay. And have you ever been a part of the credentialing committee for Dartmouth Health?

A. Yes.

Q. When?

A. I have been part of that committee since 2015.
Q. How many people are on the credentialing committee for Dartmouth Health?
A. There are a fair amount of people. So there are two representatives from every system member, meaning all the hospitals that are affiliated with Dartmouth Health. In addition to that, there are some members at large or members of the medical staff that have been selected and voted to be part of that credentialing committee.
Q. How many people would that be? And just an estimate would be --
A. So I'm going to do the math in my head thinking about all the members. So probably at least 15 to 16 people.
Q. Okay. And, in terms of credentialing, what is the role of the credentialing committee?
A. So the committee really is responsible for verification, meaning, when someone applies to be part of the medical staff, there is a process that you want to validate that what they say they can do and who they say they are is actual. The other thing that the committee does in the office is validate people's license, make sure that their license is indeed an active license. They seek to and do queries as it relates to any claims or suits that the provider may have had.
They also query what's called the National Practitioner Database, which is a place where outcomes that may be adverse

are reported. There are some mandatory reporting requirements. They validate that you went to the school you said you went to, and, also, as part of that, also receive letters of recommendation. So there is a broad list of different things that they have to verify.

Q. Okay. Do you know -- you may have been asked this what is now maybe two weeks ago -- I'm not -- maybe a week ago -- actually, it is a week ago. Do you know the plaintiff in this case, Dr. Porter?

A. I do know Dr. Porter.

Q. Okay. Did you ever work directly with her?

A. I worked in the same office briefly in Concord. She was in -- she came to Concord as an outreach when I was the medical director there, and then, obviously, when I was in the medical center in 2015 as a member of the department, I was in the same office, but we didn't really see each other very frequently.

Q. When you worked in the, when you worked in the outreach clinic with Dr. Porter, what was your, what was your general impression of her style and interactions with staff?

A. So I did not interact with her very frequently there, though we were in the same department when she came down. I was the medical director at that time for that division. And so the interaction with staff, I would say that some of the feedback I got from staff was she wasn't very engaging of them.

THE COURT: There's an objection.

ATTORNEY JONES: This is hearsay.

THE COURT: Okay. I'll ask you to approach on this issue.

(Bench conference begins.)

ATTORNEY JONES: She testified that she had not much interaction with Dr. Porter, and she's now going to convey what staff reported to her. I think that's hearsay and should not be permitted.

ATTORNEY SCHROEDER: The question was, What was your general impression? She said the feedback. She didn't say this person said that or that person said anything.

THE COURT: It's functionally the same thing, though, isn't it?

ATTORNEY SCHROEDER: Not necessarily. I don't know if it was in writing. She can testify to that.

THE COURT: Whether it was in writing or verbal, isn't that feedback, isn't that a statement?

ATTORNEY SCHROEDER: Yes, it's a statement, but I would submit that I was asking about her general impression of her.

ATTORNEY JONES: When she first answered, she said, I didn't have much interaction with her. She then pivoted into what other people were telling her, and that's when I objected.

ATTORNEY COFFIN: It's also we've had tons of testimony along these lines from both sides, and there's been

technical argument that could have been made and sometimes were not, but they've been essentially rejected in favor of a general, Hey, what was your impression based on what other people said about that? She's in a supervisory role, and this comes to directly to Dartmouth-Hitchcock's motives, what's the understanding of this person.

THE COURT: So, to the extent that she had conversations with people if this can be interpreted as conversations with people in this department relevant to this, wouldn't she be entitled to kind of give essentially the other side of the conversation, if that's what actually going to get into?

ATTORNEY JONES: She's testifying about her so-called impressions of Dr. Porter's style. She's now going to talk about other people's impressions. Presumably, we'll have more testimony about how difficult she was, but she's conveying, now she's a medium for somebody else's impression.

ATTORNEY SCHROEDER: I agree with my brother, Tris Coffin's, comments. The amount of hearsay that's been allowed, whether objected to or not, as the fact that we would now, at the late hour on the tenth day of trial --

THE COURT: So wait a minute. The amount of hearsay that's been allowed, you're saying improperly?

ATTORNEY SCHROEDER: No. I think there's been objections.

THE COURT: Sometimes.

ATTORNEY SCHROEDER: Sometimes, right, and they've been overruled. Generally speaking, I believe --

THE COURT: Hold on.

ATTORNEY SCHROEDER: I think the testimony in this case, we've spent more -- we're going to be able to move on from this immediately, and Mr. Coffin's comments, though, are true that the amount of hearsay that's been allowed. This goes to her impression and what she understood in the interactions in that office with her.

ATTORNEY JONES: If it was her impression, I wouldn't be objecting, but she's going to convey other people's impressions. That's my problem.

THE COURT: It is true. There has been testimony up until now, though, without attributing actual statements to people that conversations have happened and, as a result of that, some folks have reached conclusions, and I think this gets kind of in the same -- you shouldn't be asking her about specific comments or statements.

ATTORNEY SCHROEDER: I would not.

THE COURT: I think this is kind of like a one-question area.

ATTORNEY SCHROEDER: It was.

THE COURT: And you're going to ask her what was her impression as a manager based on kind of her general--

ATTORNEY SCHROEDER: Style, yeah, pretty much.

THE COURT: And then you're going to be able to come back on cross and reestablish your point that it's not based on personal knowledge, so --

ATTORNEY SCHROEDER: Thank you.

(Bench conference ends.)

BY ATTORNEY SCHROEDER:

Q. Dr. Padin, in terms of your role back in the days of the outreach clinic in Concord and when you would have some interaction with Dr. Porter, what was Dr. Porter's reputation, as you understood it?

A. From a clinical perspective, she was someone that people did respect clinically. The program did end there because of the demand was not that great, frankly, in terms of patients that were seeking more subspecialized REI.

Q. Okay. What about her reputation nonclinically? And I don't want you --

A. Can you clarify?

Q. Sure. What was your, in terms of her reputation as far as her interactions and style with staff and other people in the department?

A. I mean, I think she went, did her work, and sort of kept to herself, but really did not interact much with the staff. We had some challenges as it related to documentation.

Q. What were those challenges?

A. That they were not completed in a timely fashion. So there were times when I did have to call Dr. Reindollar to request that the charts be completed and closed so that the referring clinicians could know what the recommendations were.
Q. And, when you say the charts weren't timely done, who are you talking about?
A. The charts that Dr. Porter was supposed to complete as part of the encounters for her consults.
Q. And why did you have to reach out to Dr. Reindollar?
A. Because he was her supervising clinician as the chair of the department.
Q. And did that happen on more than one occasion, that you had to reach out to him?
A. Yes.
Q. And that reason, that related to Dr. Porter's completion or noncompletion of the charts?
A. Correct.
Q. How would you describe, just based on your -- now, when you assumed the CMO position between 2015 and 2020 at Dartmouth-Hitchcock Medical Center, how would you describe Dr. Porter's personality, your own impression?
A. I did not interact with her much during that time, so it would be unfair of me to sort of make a judgment. But, when I did see her as well as other members of the department, overall, they were all very cordial.

Q. Okay. And, in terms of -- do you recall testifying last week about the fact that you were proctoring a surgery for Dr. Porter?
A. That's correct.
Q. Okay. And that happened sometime in the April 2017 timeframe?
A. Yes.
Q. Okay. And you commented at that time she was a talented surgeon, correct?
A. Yes, that's correct.
Q. And you were, you made yourself available to proctor that particular operation, correct?
A. That's correct.
Q. In your belief, is there a difference between a talented surgeon and, say, a talented provider?
A. I think a provider, a good or talented provider is someone who is rounded in all areas. There are a lot of talented surgeons, but a good provider is not just talented as a surgeon. They have good bedside manner. They are professional to their colleagues. They are team players. They do what I will always sort of say that, with privilege comes duty, and there are duties that we all do, some which we may not like, but we still do them as part of our obligation to serve our patients.
Q. And, in terms of Dr. Porter, you certainly thought she was

talented in terms of her technical skills, correct?
A. Correct.
Q. Okay. But, in terms of whether or not she was a good provider or a talented provider, what was your impression of her?
A. I think there were some challenges.
Q. And what were the challenges?
A. I think it was more as to how she related to some of her team members.
Q. Okay. And did you have an experience -- did you have an understanding -- so in 2015-2016 the REI division was part of the OB/GYN department, correct?
A. That's correct.
Q. And did you have a sense of whether or not there was any tension within the REI division at that point?
A. I think there was tension in the whole department, and a lot of it was associated with challenges around staffing and turnover, and that was certainly palpable when you walked in.
Q. And what do you mean by that when you say palpable?
A. Well, you know, you would walk in, and, certainly, it wasn't the -- you didn't feel like you were in a friendly environment. You would walk in, and there was, there was a lot that was not said, and people tended to not really interact with each other in a very friendly or sociable manner, even when you're working side-by-side. So it was palpable that

there was, I would, not a lack of trust, but a sense of sort of separation, of everyone just sort of kept to what their work was, but they didn't really relate to each other.

Q. And did, and was that generally the atmosphere, if you will, in the REI division?

A. The REI division was just one of the many divisions, but you could feel it across all of divisions in that department.

Q. And, in terms of just the REI division, were there challenges in staffing and turnover during that timeframe?

A. Yes. My understanding was that there were challenges in staffing and turnover.

Q. And did you -- did Dr. DeMars ever contact you to discuss challenges in staffing in the REI program specifically, REI division specifically?

A. Yes, she did talk to me about it and was concerned about it.

Q. And did she identify issues in team dynamics and challenges in staffing as well as turnover?

A. She did share that with me.

Q. In terms of your -- I just want to go back to your training as a generalist in the OB/GYN department. Did you perform services as a generalist in the OB/GYN department related to reproductive endocrinology?

A. As it related to diseases that impact reproduction, yes.

Q. Okay. Did you perform, or have you performed as a

generalist in the OB/GYN department, advanced laparoscopy?
A. Yes, I was credentialed in advanced laparoscopy. I was credentialed robotic surgery. I was credentialed in pelvic floor reconstruction procedures.
Q. What about myomectomies?
A. Myomectomies were part of the things that were in my credentialing and in my privileges.
Q. And you performed all of these, have performed all of these procedures throughout that time period?
A. Correct.
Q. Okay. Going back to the time REI division, with respect to do you recall, prior to the REI division's closure, having any concerns about the REI division and its ability to perform satisfactorily?
A. I think there were several concerns associated with the REI division. Among them was the concern of the consistency of the ability to grow the program in volumes, particularly if we think about the -- and that was part of the reason that they had had some outreach clinics to the south was because, if you think about New Hampshire, the area that we serve in our clinics in the south has probably the largest population in the state. So our service catchment area has about 800,000 people.
And so what we were seeing was really an increase of programs in the southern part of the state that offered those services, which patients chose to go to because of convenience

and reputation. So, certainly, we were seeing a degradation of volume referrals, and so that was a concern.

I think they had had an outreach clinic in Manchester that had had a longstanding nurse there that was leaving, and it does require nurses to have a certain scope of practice and ability to work in REI, particularly when they are, when you have patients who are going through cycles of stimulation in order to be able to get pregnant, in, describing that in lay terms. And that nurse was leaving, so there was concerns whether they would be able to maintain that outreach clinic where there was a broader population base for capture. There were also turnovers of staffing at the medical center as it relates to the department at that time, so yes.

Q. In terms of the nurse, you said there was an outreach clinic for the REI division in Manchester, New Hampshire, correct?

A. That's correct.

Q. Do you recall the REI nurse being staffed there by the name of Marlene Grossman?

A. That was her name.

Q. Okay. And do you recall that she left or resigned from Dartmouth Health in and around April 2017?

A. I don't remember the exact date, but I knew she was leaving.

Q. Okay. And did that happen immediately before -- do you

recall whether or not that happened immediately before the REI division closure?
A. I, again, I don't recall exactly the date, but I knew that she was leaving, and Dr. DeMars was concerned around the staffing.
Q. Okay. And, to your knowledge, were there any other REI nurses staffed for that particular office?
A. Not that I'm aware of.
Q. So that was a challenge, right?
A. Yes.
Q. Okay. In terms of your own practice and to the extent that you -- did you have patients that required REI services?
A. I certainly had patients. REI is a component of all of our generalist training because we do manage diseases that impact reproduction and fertility, but it is not the full scope of what we are trained to do. So, for example, I would not be -- I am not trained, while I have been exposed, and I do not hold as a privilege, for example, doing an IVF cycle or doing oocyte retrieval. That's not part of my scope of privilege. That would be a privilege held by someone who has done fellowship training.
Q. So, prior to the REI division closure, did you refer your own patients internally to the REI division to the extent that they needed services outside your scope, or did you use outside providers to do that?

A. I referred to Boston IVF.
Q. Why?
A. For a number of reasons. The preponderance of my patients were in the southern part of the state and did not want to travel to the medical center to have their services rendered there. There were offices that were easily accessible in the southern part of the state from a transportation perspective to my patients, and, frankly, they had a very well-established, broad program with a lot of providers, and they were very responsive in terms of their consultations.

And many times for them, too, it was a collaborative process where they might evaluate the patient and make a determination, for example, that the patient needed a hysterosalpingogram, for example, which is an imaging study that you do in radiology to assess the cavity of the uterus. Or they needed a laparoscopy, and they would refer them back, too, to do that component, and it was more a comanagement for things that were within our scope, obviously, not things that would not be, we, things that we could not do safely or appropriately based on our training.

Q. In terms of the patient population and the demographics of that, what knowledge do you have regarding that issue specifically regarding, you know, women of a certain reproductive age group?
A. Can you clarify your question?

Q. That was not a question, very good question. You talked about where your clinics in the south because that's where the population of New Hampshire was. Just so that the jury understands, what knowledge do you have about the data and demographics, patient population, specifically the subgroup of patients who may be seeking reproductive endocrinology and infertility services?

A. So we do track our referrals, if that's what you're asking, as it relates to infertility programs. So a good example would be, in 2027 (sic.) from January through May, we had 58 referrals that went out for reproductive endocrinology infertility, and of those 2 went to Dartmouth, and the rest went to Boston IVF and New England Fertility Centers.

Q. And, in terms of comparison, comparing the volume practice or size of practices of the REI services, there's been testimony, and you've just testified about Boston IVF, New England -- is it New England Fertility?

A. New England Fertility Centers, yeah.

Q. New England Fertility Centers. In terms of the volume, say, in early 2017 and the volume of patients seeking REI services, how would Dartmouth Health's REI division stack up in terms of a volume of patient volume?

A. I don't know what their total volumes were at the medical center, but what I do know is that the preponderance of the volumes from the southern part of the state were not coming to

our program for the reasons I have enumerated prior.
Q. In terms of the REI division closure in May of 2017, I want to just ask you about the status of the overall OB/GYN department at that point. Are you aware of any plans to refocus Dr. Porter to OB/GYN upon the closure of the REI division?
A. No.
Q. Okay. I want to ask you about your thoughts on the feasibility of potentially having her reassigned to the OB/GYN department. In the summer or May through summer of 2017, did the OB/GYN department have any need for somebody with the subspecialty practice that Dr. Porter had, or were they looking for generalists at that time?
A. I think the biggest need the department had at that time was more for generalists. The reason for that was they were also struggling with coverage of the labor and delivery unit. At that time, there were two MFMs, which are the maternal fetal medicine doctors, who could do OB, but, again, as I mentioned before, they could not necessarily manage emergency procedures or gynecological issues that arose or came through the emergency room, and, when you're on call, you cover both.
In addition, we really needed someone who, in their scope of practice and in their privileges, had the ability to do intrapartum management, meaning care for women in labor, somewhat complex conditions at the time of delivery, and,

certainly, a generalist was able to do that.
Q. Okay. And do you recall, during that timeframe, actively recruiting generalists?
A. We actually did open a generalist position because that was what the department needed was someone who could do both things.
Q. And, to your knowledge, was Dr. Porter, did she have obstetrics privileges at that point?
A. She did not have the ability to do intrapartum management at that point. She was a fellowship-trained REI, and her focus was not obstetrics from an intrapartum and delivery perspective.
Q. So, in terms of what the needs of the department in the OB/GYN department at that time, is it fair to say that you did not have a need for Dr. Porter's subspecialty expertise?
A. What the department needed at that time was a generalist who could do both GYN and obstetrics.
Q. Right. And she did not have the -- did Dr. Porter have the appropriate privileges for what you needed?
A. Not for the obstetrical perspective.
Q. In terms of the REI division closure, as the CMO at Dartmouth Health, was the closure of that division at that time the right decision, in your opinion?
A. Yes.
Q. Why?

A. I think for all the reasons we have enumerated. It was a program that had a lot of challenges. It was also a program where the long-term sustainability as it relates to patient referrals and where the population was growing was in question. It was a program that had staffing challenges as well, and it was certainly a program that had some internal personal challenges as it related to the professional staff.
Q. And did you believe that that was the right decision then?
A. I said "yes".
Q. Okay. And, now, eight years later do you still believe it was the right decision to close the REI division?
A. Yes.
Q. How would you compare the atmosphere of the general dynamics of the OB/GYN department in general between, say, 2017 and today?
A. I think there are a lot of things that have changed in the department that have made the department more productive. So, for example, some of the staffing challenges have been addressed. And everyone knows, when there's staffing challenges, there is stress, and, when you're more appropriately staffed, people are in a happier environment.
Q. What about in terms of interpersonal relationships and just in general the environmental working environment?
A. I think the working environment is more collegial.
Q. Okay. What about in terms of leadership of the OB/GYN

department then and now?
A. Well, the leadership is different now, and I think the leadership now has focused a lot in team building and building up the department and the resources and the staffing, and that has contributed to a better sense of well-being among the practitioners, and I think there's been also a lot of new hires within the department which, again, has helped significantly and, certainly, people who are really, you know, great team players and communicate well together.
Q. And, in terms of comparing -- who is the current chair of the OB/GYN department?
A. Ilana Cass.
Q. And how long has she been in that role?
A. I don't recall exactly how many years now, but it's been at least three or four years, I would say.
Q. And, in terms of her leadership abilities versus, say, Dr. Leslie DeMars, how would you compare them?
A. Very different leadership style, but Ilana had held leadership roles before. So I think that that was, you know, certainly, she was more experienced.
Q. And did you encounter, back in the day when Leslie DeMars was the chair of the OB/GYN department, interim or otherwise, any challenges in her leadership abilities?
A. I think Leslie was an excellent clinician as a GYN oncologist, but my sense was that she had taken the position

out of a sense of duty since they had a chair leave, and I could feel she was challenged by it.

Q. And, in terms of the -- the closure of the REI division happened in May of 2017. Are you aware of any plans formally to reopen the REI division in any way that it looked like back in 2017?

A. No.

ATTORNEY SCHROEDER: Thank you.

THE COURT: Okay. Cross-examination?

CROSS-EXAMINATION BY ATTORNEY JONES

Q. Thank you, Your Honor. Good morning, Dr. Padin.

A. Good morning.

Q. You testified during the questioning we just heard about a time when you had challenges with Dr. Porter's documentation when she was doing visits at the Concord clinic. Do you recall that?

A. That's correct.

Q. Isn't it true that that happened during a time when Dartmouth Health was upgrading their charting systems and was going towards a computerized electronic chart system?

A. I don't recall exactly if that was the time.

Q. But there was a time when that happened, right?

A. We already -- we've had an electronic chart system since 2000.

Q. But there was a time, though, when some members of the

health system had converted to the electronic chart system and others had not? It took time to get everybody onto the new system, right?

A. Yes.

Q. And isn't true that there was a time when both Dartmouth-Hitchcock Medical Center in Lebanon and the outreach clinic Manchester were on the electronic system, but the Concord system was not yet on the electronic system?

A. The Concord system, I don't recall exactly the time of the transition, so I can't, with certainty, say that, during that time, we were, had not transitioned to Epic yet.

Q. But there was a time when there was a lag, though, right, when both Lebanon and Manchester were online, but not Concord?

A. Yes, they did go live before. That is correct.

Q. Right now, isn't it true that, during the time that you say you had concerns about Dr. Porter doing her charts, that, when she went to do the visits in Concord, she, in fact, did her notes and submitted the charts in a timely manner on the electronic system that DHMC had and she did not know that the Concord system had entered a duplicate visit?

A. I am not aware that that was the concern.

Q. Okay. Isn't it true that, after you called Dr. Ryan -- gold?

A. Reindollar.

Q. Dollar. I'm sorry. I can't get that name right, but

thank you. After you called him, the IT department at DHMC was able to correct the system by deleting the duplicate charts because it was true that Dr. Porter's notes were timely submitted?

A. I cannot say that that was the case. I am not privy to that, and I cannot speculate on that.

Q. So you can't dispute that?

A. I cannot dispute, nor can I verify that. What I can say is that, indeed, in more than one occasion the charts were not completed, and it required me to do multiple calls over time to Dr. Reindollar.

Q. Okay. But, at that time, Concord had not yet converted to the electronic system?

A. Concord was on an electronic system, but not Epic.

ATTORNEY JONES: Thank you. No further questions.

THE COURT: Any redirect?

ATTORNEY SCHROEDER: Nothing, Your Honor.

THE COURT: Okay. Thank you, Dr. Padin. You may step down. Okay. So, at this time, we'll take our midmorning break.

(The Jury leaves the courtroom.)

THE COURT: Okay. So that concludes the defendant's case. I'll ask you that question when the jury comes back to put it on the record, if that's accurate.

ATTORNEY SCHROEDER: Yes, it is accurate, Your Honor.

THE COURT: Okay.

ATTORNEY SCHROEDER: At which time I would make a renewed motion for directed verdict.

THE COURT: Okay.

ATTORNEY SCHROEDER: On all of the same grounds that we had submitted previously, but with even more specific hyperfocus on the fact that there is no evidence relating to specifically the only issue on the disability discrimination part of this case in terms of termination versus reassignment, potential reassignment. As I'm loath to get into all the back-and-forth of the Second Circuit's hundred-page opinion, but what is clear from that opinion is that the only part of the disability discrimination case relating to termination is whether or not the defendants were under a duty as a reasonable accommodation to reassign Dr. Porter to some other position.

And the Second Circuit referred to, well, perhaps there was an OB/GYN position available, or perhaps there was a position in radiology, and what you have heard is unrebutted testimony that there was no position available that Dr. Porter was privileged in in OB/GYN at that time, and there was no availability of a position in a part-time capacity to read gynecologic or early obstetric ultrasounds either.

So the evidence in its totality in the record, so whatever the Second Circuit said, that evidence is not in the record. So perhaps there were inferences that they made, and they made

a lot of inferences, but that evidence is not in the record of this case, and, in fact, it's contrary to it. It is clear that there was no position that Dr. Porter, an existing open, vacant position that Dr. Porter could be reassigned to.

And the law on that, Your Honor, respectfully, is clear. Not just the Second Circuit, the Fifth Circuit the Sixth Circuit, the Eleventh Circuit, there is -- in fact, it's the statute. So we could talk about the scope of reasonable accommodation and the terminology of reasonable accommodation, but the law is clear, the statute is clear, the regulations are clear that there was no existing vacant position for which Dr. Porter could be reassigned. And so, for that reason alone, that part of this case should, should be dismissed at this juncture.

In addition, we renew all of the arguments that we had for purposes of our initial motion for directed verdict. Thank you very much.

THE COURT: Okay. And so, on the point that you were just making about the reassignment question, what, in your view, is the role of credibility of witnesses to conclude what you have just argued?

ATTORNEY SCHROEDER: There is no --

THE COURT: It's not clear.

ATTORNEY SCHROEDER: There is no need to even get to credibility, Your Honor.

THE COURT: But I guess my point is -- so you're talking about the testimony this morning of Dr. Padin primarily, right?

ATTORNEY SCHROEDER: No, Your Honor.

THE COURT: Well, definitely that's included?

ATTORNEY SCHROEDER: Absolutely, yes, absolutely.

THE COURT: So you're saying it's evidence that's established and so there isn't really a jury question there. My question for you is, In terms of the Rule 50 standard, what is the kind of the role of the jury there in interpreting or weighing the credibility of those witnesses before they credit that kind of evidentiary foundation?

ATTORNEY SCHROEDER: So what I would submit, Your Honor, is the burden of proof is on the plaintiff, and the burden of proof is to establish that there was an existing vacant position. There was no testimony, record evidence or testimony, that there was an existing vacant position by the plaintiff in this case. There is no testimony to that effect.

In addition, we then have the testimony by our witnesses to refute even the notion that there was, and so we didn't need the testimony necessarily, but, obviously, if it goes to the jury, we have the credibility issues, and then it would be up to the jury to decide that issue based upon the credibility of the witnesses, the testimony, and the documentary evidence before the Court.

But you don't even get there, Your Honor. You get -- you start with and end with the plaintiff's case in chief. There is no evidence in the record by the plaintiff that there was an existing vacant position in the REI, in the OB/GYN department or the radiology department. In fact, they didn't even ask any questions of Dr. Padin or Dr. Chertoff on those two issues. So, to the extent that they could have or should have or maybe wanted to create a potential issue to go, a factual issue to go back to the jury, they didn't even do that.

But you start with the plaintiff's case in chief, and you end there. There is no evidence in the record of an existing vacant position that possibly could be a reasonable accommodation under the ADA or Rehab Act.

THE COURT: Okay. Thank you.

ATTORNEY SCHROEDER: Thank you.

THE COURT: Any response?

ATTORNEY JONES: Yes, Your Honor. These are the same arguments they made earlier, and we renewed our arguments at that time as well to start. Second, quite frankly, there is plenty of evidence that, from which the jury could conclude that there was ample need for Dr. Porter's services. The Emily Baker email which was used in cross-examination for Dr. Chertoff, the testimony of multiple witnesses talking about the unique skills that Dr. Porter had that were essential and the devastating impact to the remaining OB/GYN department with

her not being able to perform those.

So certainly enough of an inference for a jury to conclude that they could have, and, actually, witnesses were saying they needed her. The fact that we have somebody calling Dr. Porter to ask her to walk her through a procedure by phone after she had been fired proves that there was an ongoing need for her unique services. So there's plenty of evidence that is part of the record that the Second Circuit considered and from which the Second Circuit concluded a reasonable juror could infer that the failure to reassign was part of this case.

And I'll point out in a hundred pages the Second Circuit frequently described this case as wrongful termination and failure to retain. So the idea here is, yeah, they closed the division, but they also acknowledged that the failure to retain Dr. Porter to perform those essential services is a part of the analysis of the general discrimination claim in the first instance. So this is not a situation where an employee says, I have a disability, and I need an accommodation. I can't perform my current job; therefore, I would like you to assign me to another job. And, in that case, if there's no current available position, then, correct, it's not a reasonable accommodation if there's no currently available vacant position.

That's not this case. This is a case where Dartmouth shut down the whole division. We allege that that was all part of a

ruse to just solve all of the problems, get rid of the incompetent doctors and get rid of the whistleblower. But so it's all part of the global analysis of that decision, which was the ultimate goal of which was to get rid of Dr. Porter and not even consider retaining her in any capacity, particularly the capacity in which multiple witnesses, through email and testimony in this trial, said were essential. So we produced plenty of evidence from which a reasonable juror could conclude in Dr. Porter's favor, and this motion should be denied.

THE COURT: Okay.

ATTORNEY SCHROEDER: If may I be heard very quickly Your Honor, your just very quick rebuttal?

THE COURT: Yes.

ATTORNEY SCHROEDER: We put a bench memo in to Your Honor on the issue that you asked us to brief relating to the import or lack thereof of the Second Circuit decision. The Second Circuit made all sorts of inferences for purposes of the summary judgment standard. What the Second Circuit said, though, were inferences that had to be proven through admissible evidence in this court in this trial, and that has not happened.

We cited a flurry of cases to support our position that there was no evidence by the plaintiff in this case that there was an existing vacant position to which she could be reassigned. The email that Mr. Jones referred to, Dr. Baker,

she is not even a generalist; she's in the MFM part of the OB/GYN department, and that was an email that Dr. Chertoff was not even on. And they certainly could have asked questions of Dr. Padin about it. They chose not to. But it doesn't matter. It's not something that was in -- that email by itself does not get them there.

The law is clear, and, in fact, they have not cited any case law to rebut the four Circuit decisions that we cited in our original motion for directed verdict. The law is clear on this, and, if the law is clear, I'd submit respectfully that the Court can award us dismissal of that part of this case at this point. There is no evidence to go forward on that specific point.

Whether somebody thought highly of Dr. Porter and her skills is one thing, but that doesn't establish that there was an existing vacant position, which is the requirement under the ADA and Rehab Act, in order to demonstrate sufficient evidence that there might be a reasonable accommodation possible. There is not even a possibility of that even put into testimony in this case, a specific existing vacant position to which Dr. Porter could have been reassigned.

THE COURT: Okay. Mr. Jones?

ATTORNEY JONES: If I could just add, yesterday there was testimony during Mr. Herrick's time on the stand, and we introduced Exhibit 50A, or maybe, I think, defendants even

introduced it. That was a plan for what might happen after REI was closed, and it's at that point in time they were envisioning a role for Dr. Porter. So they were envisioning a position. Eventually, someone decided against it. But there was certainly a position contemplated that she could have been performing there.

Second of all, you know, part of the case is also that they didn't even engage in an interactive process to explore other possible accommodations. So this is not, again, this is not the case where you have an employee who finds themselves unable to do their job and is now seeking a new job as an accommodation for that disability and the question becomes, Is there an open, vacant position? This is a much more complicated scenario with a much more complicated factual background, so the cases they're citing just aren't applicable to this situation.

THE COURT: Okay, all right. Thank you. I'm going to step off and considering the arguments, and I'll return.

(A recess was taken from 10:41 a.m. to 11:03 a.m.)

THE COURT: Okay. Hopefully everyone had a little bit of a break there. This is the break for everyone, so we'll be bringing the jury back after this discussion. Actually, I need to bring up the rebuttal issue as well.

Okay. So, with respect to the renewed Rule 50(a) motion, so I'm going to deny it again at this time, specifically with

respect to the more pointed issue. I recognize that defendants have renewed the motion on all grounds that were raised previously, but, focusing on the one that was specifically raised today, and that's the reassignment or duty to reassign, you know, considering all of the evidence that has come in, I won't, I won't specifically lay out the evidence that I cited in considering the last Rule 50(a) motion, but I incorporate it here now.

And that includes Dr. Porter's testimony about communicating with Dr. Merrens about her interest in an OB/GYN position that didn't focus on fertility, the evidence of Dr. Porter's medical skills that has come in. I do think a reasonable jury could conclude that she was qualified for another position, and, as I said kind of during the argument, I recognize the defense argument that there has been testimony about the unavailability of a suitable position, but I do think that question is kind of bound up with the jury's consideration of credibility as to the testimony that they heard related to that particular issue. And there is some evidence in the record to support plaintiff's claim that there was a lack of engagement in the interactive process about a potential new position. So I think all of this together establishes that granting a Rule 50 motion at this time would be inappropriate.

And, with respect to the renewal of the other arguments that were made, the motion is denied for the same reasons I

gave at the last Rule 50(a) discussion.

So, with respect to rebuttal, so who has the issue here? Is it Mr. Schroeder that you wanted to talk about or Mr. Coffin?

ATTORNEY SCHROEDER: I'm going to hand it over to my able cocounsel.

ATTORNEY COFFIN: He gives me all the tough issues, Your Honor. No. We just wanted to have a little discussion with the Court before the rebuttal begins. Rebuttal is intended to respond to issues raised by the defendant in their case and not sort of an attempt to go back and rehash earlier issues that were discussed or could have been discussed in the case in chief. Obviously, the Court has discretion on that, and there are multiple reasons you can allow rebuttal testimony, but we would ask for a little bit of discussion before we begin into this so that the parties understand the Court's considerations on these and the guidelines.

And, again, we would just sort of say that rebuttal here really should be narrowly focused on responding and not rehashing or relitigating or restating things. It's not an opportunity for them to begin anew their presentation.

THE COURT: Right. I can't imagine there's disagreement on that concept, but I'm glad you're bringing up the standard. I think it's worth it for all of us to consider what the appropriate standard is.

So, yes, as far as the law on kind of the permissible scope of rebuttal evidence, it's not meant to be a buttressing of the case in chief. I'm sure plaintiff's counsel is very well aware of that principle. Though, in reminding myself this morning doing a little bit of research, the federal procedure treatise, I guess I'll call it, with an update from March 2025, I'll just explain this or read this to the parties.

It says, "Rebuttal evidence may be introduced to explain, repel, contradict, or disprove an adversary's proof. The proper use of rebuttal evidence includes the contradiction, impeachment, or diffusion of the impact of the evidence offered by an adverse party. Rebuttal evidence may be used to challenge the evidence or theory of an opponent, not to establish the case in chief. Testimony offered only as additional support to an argument made in the case in chief, if not offered to contradict, impeach, or diffuse the impact of evidence offered by the adverse party, is improper on rebuttal".

So it's not simply what specific items of evidence did the defendants raise and then rebuttal is only allowed to address that. It seems to me it's a little broader than that in terms of dealing with the theory or potentially impeaching the nature of the evidence that has come in.

With that as kind of a general roadmap, Mr. Coffin, are there specific areas of concern?

ATTORNEY COFFIN: No, I think that, hard to argue with the hot-off-the-presses court guide, and I think that essentially states what I was trying to say. You know, we do not have a proffer of evidence as to at least one of the witnesses, Attorney Lee, who they are going to call, and it would be interesting to hear that. I don't know whether she is straight rehash or not, and, if the Court thought it appropriate, it might be helpful to understand. If you can give us some kind of a proffer of her testimony, it might make this completely moot and eliminate a sidebar soon when we get into areas that we wondered about. That's all.

THE COURT: Okay. Who is speaking for plaintiff? Okay, Mr. Jones.

ATTORNEY JONES: Thank you, Your Honor. I'd be pleased to give a brief proffer. I am aware of the limits of a rebuttal case, and I believe our evidence will be within the bounds of a rebuttal case. We intend to call a witness who was a patient of Dr. Hsu. She will testify about an adverse outcome she experienced.

THE COURT: Is this, and which witness is this, Mr. Jones?

ATTORNEY JONES: Eunice Lee.

THE COURT: Okay. So that's a patient of Dr. Hsu?

ATTORNEY JONES: Correct.

THE COURT: All right, go ahead.

ATTORNEY JONES: So she will testify about her experience, including highly unusual and prolonged pain after his procedures. And the timing of this procedure was six months after Dr. Porter had submitted her 11-page assessment of Dr. Hsu putting the hospital on notice that he should not be performing these procedures because they caused patient harm. So she will verify that he, in fact, caused patient harm.

We believe it rebuts the defendant's case in chief in several ways including, but not limited to, through several of their witnesses, they've gone to great lengths to try to minimize Dr. Porter's complaints and to characterize her as simply a disagreeable person who didn't play well with others and that she didn't have a legitimate complaints of actual patient harm. This witness will prove that, in fact, what she was complaining about was causing patient harm. And, also, I very pointedly cross-examined Dr. Merrens yesterday about his knowledge of the evidence in this case, the theories in this case, and his knowledge of all the evidence of harm, and still he testified that he was unaware of any actual harm, and we intend to directly rebut that testimony.

So we think it is rebuttal and it's clearly relevant. It's relevant to the case in that it corroborates Dr. Porter's complaints. The actual harm to patients is why Dr. Porter blew the whistle louder and more persistently as time went on, which is what our theory is ultimately angered Dr. DeMars to the

point of terminating her employment.

And, finally, we think it's highly relevant with regard to punitive damages because we believe it's outrageous that this institution was aware that Dr. Hsu was causing patient harm and allowed him to continue to perform procedures. So, for all those reasons, we think it's clearly relevant and tailored as a rebuttal to the case in chief, theory of the case, and testimony.

THE COURT: Mr. Coffin?

ATTORNEY COFFIN: Well, I'd just respond. This sounds like we're going to have a mini-malpractice action without expert witnesses, without Dr. Hsu being able to respond or rebut. My understanding -- correct me if I'm wrong -- is that this patient never filed a claim. There's been no adjudication of any conduct outside of the standard of care.

Obviously, harm is a loaded and ambiguous term. You know, often completely normally patients will have some pain when they go and are treated completely properly by a health care provider, and what's necessary under the law is for an expert to testify and ground that as being outside of the standard of care. Here, we're going to be having this witness come in and describe in graphic terms, you know, an experience that she had, I presume, with the implication that it was outside of the norm and improper, and there's been absolutely no adjudication or expert support of that as you'd have in a normal case.

Under those circumstances, if that's what this witness is offered for, I think we've got a major 403 problem here, Your Honor, and we've had no chance to know this was going to happen. I did try and call Attorney Lee -- she did not return my call -- when this was disclosed, and, you know, it's the kind of thing that, had we known she was going to talk about a granular treatment issue that caused her harm, which I understand to mean treatment outside of the standard of care resulting in injury which was not claimed and supported in the regular way, we would have appropriately prepared to respond to that.

ATTORNEY JONES: Quickly. She's going to testify that she had IVF experience in Denver, IVF experience at Dartmouth-Hitchcock, and IVF experience at UVM, and she's going to testify that she knows what the normal procedure is, what the normal cramping might be after a procedure, and she's going to testify that Dr. Hsu's procedure left her in excruciating and disabilitating pain for days and it was extraordinary. She can testify to her own experience. He can ask cross-examination. This isn't a malpractice allegation. This is establishing that, in fact, Dr. Hsu caused patient harm.

ATTORNEY COFFIN: Well, specifically, she's had three experiences with three different IVF practitioners. She knows -- I'm trying to quote here -- what the normal amount of pain a patient should get from IVF. I would submit that that's

exactly the kind of thing that 403 is intended to limit, and, you know, a malpractice action based on that testimony, that evidence, would be dismissed out of hand.

And so I think it, you know, after three weeks of trial on rebuttal to bring in this witness now, which could have been brought in the case in chief and could have dealt with this as plenty of these issues were parsed is, you know, a real surprise, unfairly prejudicial, and, you know, kind of throwing this whole other issue in the hands of the jury to decide when we've had, you know, weeks of testimony on this.

THE COURT: In terms of bringing it on the case in chief, so what would have been the relevance just asking you to bring in? You know, the whole kind of point was the fact that Dr. Porter reported on other physicians. Are you saying that they should have brought in Ms. Lee to then testify about an actual incident?

ATTORNEY COFFIN: Well, I think we would have had the same position now, but it would have been part and parcel and the Court would have reached this decision, you know, earlier on in the case, and either that testimony would have been admitted or excluded. If it had been admitted, then the testimony would have happened in their case in chief. There's nothing that happened in rebuttal that makes this witness proper.

Moreover, you know, the kind of testimony we're talking

about here really is a patient's judgment on what a medical malpractice claim is based on the fact that she has had IVF experiences with different providers at different institutions. And so, you know, to me, certainly, limits have to be put on her testimony to guard against her own personal assessments. She can say that she had pain after being at Dartmouth and what her experience is with Dartmouth, but comparisons to other situations and other settings and other clinicians is, I think, you know, irrelevant, unsupported testimony.

But, you know, my kind of final point is, you know, to have a patient come in and describe a unique, singular treatment by this provider as, which happened after the fact as, you know, somehow buttressing the claim which has not been uncontested and there's been plenty of testimony about that, that Dr. Hsu had interactions with patients that were deemed by other people who were experts in this area to be unreasonable or improper. You know, that's, that's, to me, totally cumulative and at this point unsupported and a violation of 403.

ATTORNEY JONES: Can I respond to Number 1 before Number 2?

THE COURT: Yes.

ATTORNEY JONES: Thank you. With regard to the issue that Tris raises with regard to this being a patient talking about her own experience, we heard multiple doctors and

physicians and nurses in this case testify about what the normal level of pain should have been and what the pain was from Dr. Hsu. So we have the medical evidence that establishes that already. This is simply a patient confirming that her experience was, in fact, corroborative of what all the doctors have already told us.

Second, there's no surprise here. As Mr. Coffin acknowledges, he tried calling her, so they knew that she was on our list. And, third of all, this is directly responsive to their case. Two points. They have tried through repeated witnesses to recharacterize Dr. Porter's complaints as simply being middle school drama, that she's hard to get along with, she complains about everybody, and they weren't really serious patient harm complaints. So, because they took that tack, we felt the need to put on a patient to say, I actually was harmed, A.

B, Dr. Merrens testified yesterday that he denied acknowledging actual patient harm. If they had admitted it, then I probably wouldn't be standing here, but they didn't, so we're rebutting those two theories with this testimony. It will be brief.

THE COURT: Okay. So, just, you can go next, Mr. Schroeder, but, just kind of thinking generally about the purpose of rebuttal, right? So Mr. Jones is saying, which I think is consistent with the testimony, that there was

testimony from, during the defense case that there was either no knowledge of patient harm, right, or no actual harm. So, just as a legal matter, this particular proffer or proposed testimony does seem to fit within the category of rebuttal as a general concept. I don't think it's cumulative or any of the other prohibited uses that I read when I ran through the legal standard with everyone.

The question, though, becomes, further to Mr. Coffin's point, I guess, is whether there's a way that that kind of testimony, which does seem to be legally relevant on rebuttal, does not, though, get so detailed or so graphic or, you know, get, gets into basically the patient opining as to standard of care issues, which, obviously, which she wouldn't be competent to do. I guess my point is I'm wondering if, finding that it's legally relevant, is there a way that it can be tailored?

ATTORNEY SCHROEDER: I'm going to defer on that issue, Your Honor, to Mr. Coffin, but I wanted to raise a procedural point for the record, that Eunice Lee was not disclosed at any point in the disclosures by plaintiff in this case. In fact, they supplemented their disclosures in January to include Dr. Ira Bernstein. They did not include anything about Eunice Lee. The first time we saw her name was on the, just the witness list. So, in terms of the procedural rules of this case, she was never disclosed, nor was it identified what she would testify about.

And so I want to make sure that the record is clear that we're making an objection, not just on substantive grounds, but on procedural grounds as well. I'll turn it over to Mr. Coffin to deal with your specific question, but I at least wanted the record to reflect that.

THE COURT: But, just to be clear, so Eunice Lee's name was on the exhibit, excuse me, the witness list for this trial. You're not saying that you heard Eunice Lee's name yesterday?

ATTORNEY SCHROEDER: No. That was the first time, whenever, March 10 was the first time we saw her name. Now, we assumed that we didn't need to raise it because there were a whole slew of other names on plaintiff's witness list that haven't testified, but now we're at a different juncture at this case. So I just wanted to make sure that that at least was put on the record because it's an important point relating to the duty of plaintiffs in this case to identify their witnesses through their disclosures.

THE COURT: So, Mr. Coffin, before you get up, I just want to confirm with Mr. Jones. So can you explain to me again your proffer of what this testimony will be? I mean, there isn't going to be testimony, proposed testimony here by Ms. Lee as to basically, This is not how it's supposed to work, right? I mean, that seems to bleed over a little bit into kind of expert territory, perhaps.

ATTORNEY JONES: If I may defer to my colleague, Ms. Nunan, who actually will be presenting the examination --

THE COURT: Okay.

ATTORNEY JONES: -- and knows the scope better than I do.

THE COURT: Okay.

ATTORNEY NUNAN: Sure. Eunice Lee will be testifying that she had IVF egg harvest in Denver, Colorado, that she moved to the Upper Valley. She saw Dr. Porter in the fall. Dr. Porter, of 2016, went out on disability, and the egg retrieval was done by Albert Hsu. She's going to describe waking up from the anesthesia and the unusual interaction she had with Dr. Hsu at that time and what happened in the following days in terms of her experience.

She's going to testify about meeting in the spring of 2017 with Dr. Porter as the follow-up, and then she's going to testify, she can go on and testify about how she heard about the closure of the REI division and how she found out about this lawsuit and the case and, putting together what she didn't understand at the time -- she understood she had unusual pain. She couldn't understand the experience she was having in terms of why Dr. Hsu was saying the things he was to her, and then she reads about the lawsuit, a portion of the Second Circuit decision, and is stunned that her understanding of what she kind of believed was really wrong at the time is confirmed by

what she's reading, and she has to stop reading that. And the fact that she went on to have a hysterectomy and was not able to have children and her experience after that.

So that is, that is her experience. We feel like it does speak to the harm.

THE COURT: Mr. Coffin?

ATTORNEY COFFIN: So she had three years to bring a claim. Under the statute of limitations, this has now run. She, there's no way this can be kind of adjudicated. There's no way it can be meaningfully understood by the jury here, and for us to have, you know, in the plaintiff's rebuttal case this whole malpractice case narrated by a nonexpert witness without any practical way to respond at this, the 11:59 minute, is unreasonable and unfair to us.

I think, if she testifies, her testimony should be narrowly focused on her IVF treatment, how she felt after that, and none of this kind of follow-up reading in the newspaper and reacting and suddenly learning what caused this. Those kinds of things seem completely out of the competence of this witness and not relevant.

THE COURT: Okay, yeah. What is the relevance of the kind of after-the-fact proposed testimony about reading about the lawsuit and everything else? What is the relevance of that to the issues here?

ATTORNEY NUNAN: Right, sure. So she made statements

to her husband after the procedure, This is wrong. Like, I shouldn't be in this much pain. I've never bled this much before. Like, I'm, this is really wrong, and had no understanding of what was really going on behind the scenes. When she reads about it, it confirms everything she's been feeling that this was wrong, and I think that, I think that it is relevant.

THE COURT: So, I mean, reading about the lawsuit, though, doesn't confirm that everything was wrong.

ATTORNEY NUNAN: The details in the Second Circuit, that there were other women that had the same experience she did.

THE COURT: Okay, all right. Is this the -- but there's a second witness, right, on rebuttal?

ATTORNEY JONES: We initially planned to also call Dr. Porter. We have decided not to. So this will be our only witness.

THE COURT: Oh, okay. All right. So, you know, this is a little bit of an issue. I hate to keep kind of taking a break to think about it, but I do want to kind of give a little consideration to this particular issue. Mr. Coffin, are you --

ATTORNEY COFFIN: No, no. When you're finished, I did want to make a comment.

THE COURT: Okay. No. So I'm just wondering what we should do with the jury. I don't think this is going to take

forever, but I do want to kind of be thoughtful about what we end up doing with this testimony.

So I could bring the jury back in -- they've already been on a very long break -- and send them out. If I come back, you know, at quarter to 12:00 and we, you know, we have a ruling on what the issue is going to be, then we'd end up going past 1:00 o'clock before they get their lunch break. So it may make more sense to let them go now and come back. You know, I guess I could have them come back at quarter to 1:00 or so. Is that -- we can all have lunch then, and I can give you the ruling before we get going. Does that make sense to everyone?

ATTORNEY COFFIN: That was essentially the kind of thing I was going to suggest, that maybe we take a moment here. That's fine.

THE COURT: Okay. Anything else then before I bring them back in?

ATTORNEY JONES: Nothing else.

ATTORNEY SCHROEDER: No, Your Honor.

THE COURT: All right, thank you.

(The Jury enters the courtroom.)

THE COURT: Okay. Mr. Schroeder, does the defense have any further witnesses at this time?

ATTORNEY SCHROEDER: No, Your Honor. Defense rests.

THE COURT: Okay. Thank you. All right. So, members of the jury, I know you've been out on a long break,

and I'm about to tell you that you're going on lunch now for -- we're going to ask you to come back at 12:45. I know it might seem like, What are we doing here? We took a long break, and we're taking another long break. As I mentioned to you, you know, this is the way a trial works. Sometimes the Court needs to speak with the lawyers about some issues, and that's what's going on now. So, yeah, so I will excuse you now, and please be back and ready to go around 12:45, okay?

(The Jury leaves the courtroom.)

THE COURT: Okay. So I anticipate I'll be back around 12:30, and we can continue the conversation and get a ruling and then move on, okay?

ATTORNEY SCHROEDER: Yes, Your Honor.

ATTORNEY JONES: Thank you, Your Honor.

(A recess was taken from 11:31 a.m. to 12:32 p.m.)

THE COURT: Okay. Good afternoon, everyone. All right. So with respect to this issue, I have considered it over the lunch break, thought about the testimony that has come in up until now, and I have concluded that, you know, the defendants essentially have kind of opened the door to this topic of lack of patient harm, particularly with respect to Dr. Hsu. As I recall from the testimony, Dr. Merrens was asked about knowledge of patient harm and indicated no knowledge of patient harm. There was further testimony about any medical malpractice claims against Dr. Hsu. The testimony, as I

recall, was that there really was no evidence of any kind of claims with respect to Dr. Hsu.

So the proposed testimony by this witness, as I commented before the lunch break, is relevant and actually highly probative of the issues raised in this case. There has been essentially a suggestion in the defense case that there were a series of complaints by Dr. Porter and frankly a questioning of whether the complaints were legitimate, and this definitely contradicts the testimony to the effect that perhaps the suggestion is the complaints were not justified.

That said, I am going to provide instructions about the permissible scope of Ms. Lee's testimony. So she can speak about her experience generally, but she cannot speak to whether Dr. Hsu did not provide competent medical care. I think that that gets into the realm of her essentially providing an opinion on the standard of care.

I mean, really, in short, I do not want Ms. Lee to be testifying to any legal or medical conclusions. I also do not want Ms. Lee to be speaking in any way about the Second Circuit decision in this case. I'm not sure if that was her intention, but there should be no discussion of that.

To the extent that there is going to be discussion of the lawsuit, she can't say that, by reading about the lawsuit, it confirmed to her that something was wrong, right? The filing of the lawsuit doesn't confirm that something was wrong. It's

merely her reading about the lawsuit, she can talk about her reaction to that based on her own experience.

Is that, is that clear? I want to be really clear with plaintiff's counsel on this. I understand Ms. Lee is an attorney so she should be able to follow these explicit directions, perhaps even to a greater degree than an ordinary lay witness. So that's the ruling.

With respect to the procedural objection, so, as it was explained to me earlier, Ms. Lee was on plaintiff's initial disclosed witness list several weeks ago, and this witness is a rebuttal witness, right? So there may not have even been a rebuttal case. That's a decision that plaintiff makes after the defense puts on its case. So I'm satisfied that, in terms of disclosure, there was disclosure several weeks before the trial. So I won't rule that that's a basis for Ms. Lee to be excluded today.

So that's the ruling. Ms. Nunan, I understand this will be your witness. Are there any questions about what the scope of what I have just indicated?

ATTORNEY NUNAN: There are not. I would like the opportunity to go speak with her, like I did with the other witness that we limited the scope.

THE COURT: Yes. We told the jury to come back in ten minutes, so you have some time. Okay. Mr. Coffin?

ATTORNEY COFFIN: Just briefly a clarification.

Thank you for this ruling. Understood. Good guidance. On Number 4, the reaction to the story, I presume that Number 4, her reaction can't get into whether that caused her to think that something had happened that was wrong here or something. That shouldn't be part of the testimony either because that would be stating a legal or medical conclusion.

THE COURT: Right. I'm assuming -- Ms. Nunan, you know her better than all of us. You know, her reaction to the lawsuit is going to be what?

ATTORNEY NUNAN: So this is what I've heard twice from her, "When I read about it, I couldn't get all the way through it because I felt absolutely sick to my stomach. I thought I was going to throw up, and I had to walk away". That's her reaction to reading, and I, that's what she's told me twice very consistently.

THE COURT: Okay. So that's not expressing an opinion.

ATTORNEY COFFIN: Yeah, and, if confined to that, I agree with that. I hope we don't have to spill over into these other things, and I trust we don't.

THE COURT: All right. So then I'll step off, and I'll be back for quarter to 1:00.

(A recess was taken from 12:40 p.m. to 12:50 p.m.)

(The Jury enters the courtroom.)

THE COURT: Okay. So, as you heard before the break,

the defendants have rested their case. So, at this time, we're going to turn back to the plaintiff, and the plaintiff will have an opportunity -- I think I mentioned this to you in the preliminary instructions when we first started -- to present evidence in rebuttal, and we anticipate one witness this afternoon. Please, go ahead.

ATTORNEY NUNAN: We call Eunice Lee.

EUNICE LEE,

having been duly sworn to tell the truth,

testifies as follows:

THE COURT: Okay. Please go ahead.

DIRECT EXAMINATION BY ATTORNEY NUNAN

Q. Good afternoon, Ms. Lee. Thank you. Where do you live?
A. Lebanon, New Hampshire.
Q. And what do you do for work?
A. I'm an attorney.
Q. How long have you been an attorney?
A. Oh, my gosh. Since 2009, So do the math.
Q. What kind of work do you do?
A. I do estate planning.
Q. Great. I want to talk to you today about your IVF journey. Can you tell me where your IVF journey started?
A. Yeah. It started in the fall of 2013 in Denver, which is where my husband and I were living then. I, my initial consultation was with the REI clinic at University of Colorado

in Denver, and then just sort of got the process rolling around that time with the actual retrieval happening January of the following year. So 2014 is when the retrieval.

ATTORNEY COFFIN: So objection. Could we approach? I think this is subject to the earlier ruling.

THE COURT: Okay.

(Bench conference begins.)

ATTORNEY COFFIN: I think certainly some contextual questions are appropriate with the Witness, but I'd understood the Court's ruling to be that she could talk about the treatment by Dr. Hsu and there wasn't going to be a comparison of the Denver experience and later experiences that would be relevant to imply that that was what was done by Dr. Hsu was different and, therefore, not competent.

THE COURT: Yeah. No. I think it's okay for her to talk about her background and just give factual testimony on kind of her experience.

ATTORNEY NUNAN: I'll keep this to -- I heard that.

ATTORNEY COFFIN: Okay. So I didn't want to jump the gun, but I also didn't want to let the cat get out of the bag.

ATTORNEY NUNAN: This is what happened in Denver. This is what happened in Hanover. This is what happened at UVM.

THE COURT: With the express understanding that, when she gets to the Dr. Hsu portion of the testimony, there's going

to be no suggestion of kind of opinion, whether it comes up by implication

ATTORNEY COFFIN: Well, that's my concern is the questioning has to be guided appropriately and the Witness counseled appropriately, not to be designed to leave the implication that it was different here, therefore, it was outrageous and terrible because that's not what the Court ruled.

ATTORNEY NUNAN: She will talk about her experience. We've been very clear about it just needs to be what she experienced here, what she experienced there. She's not going to speak to what she thought Dr. Hsu had done.

ATTORNEY COFFIN: But what she experienced there has no relevance to this case except by the comparison that I have been concerned they are trying to make by implication exactly contrary to the Court's instructions.

THE COURT: At the same time, her ultimate testimony is going to be -- I think we know where it's going, right? It's going to be, My experience was negative with Dr. Hsu, but she knows it's negative in comparison. I don't think that's her opining as to the standard of care.

ATTORNEY COFFIN: Well, I thought the Court's ruling was that she wasn't going to be saying anything that would describe any medical or legal conclusions and nothing about Dr. Hsu's competence. Essentially, as long as we can stick to

that, that's all.

THE COURT: I expect that there are going to be no questions expressly asking her to draw a conclusion as to the standard of care. To the extent she testifies about her experience Denver and then her experience with Dr. Hsu, I think that's the facts of her experience, okay?

ATTORNEY COFFIN: Thank you.

(Bench conference ends.)

BY ATTORNEY NUNAN:

Q. I'm going to ask you to keep your voice up. I'm going to try to speak into the microphone.

A. Okay.

Q. I had asked you about your IVF journey, and you had started to talk about your experience in Denver.

A. Um-hum.

Q. You had an egg retrieval in Denver?

A. I did.

Q. What was that like?

A. I mean, it was my first one, so I didn't have another one to compare it to, but, in my experience, it went pretty well. The staff and the doctors there, you know, were great. I felt well taken care of. They ended up retrieving 20 eggs, which is amazing for anyone familiar with IVF. And then they ended up freezing four -- all of this is IVF language which might not be familiar -- but four five-day blastocysts that, on day six,

were frozen, and then after that I had a transfer in December with two other frozen eggs. It was not successful. And then followed in May with the remaining two, and that also was not successful.

Q. When you had your egg retrieval in Denver, can you talk to me about your experience coming out of anesthesia and what you felt?

A. Yeah. So, I mean, a lot of the detail I don't remember, again, because I'm under anesthesia and sort of fuzzy when you're coming out of it. I, you know, before going in I remember being told that sort of the what to expect and that, once I sort of come to, at some point, the doctor will come in and check in with me, let me know how the procedure went, and my husband will be able to come and join me. Pretty much what happened.

I mean, I was a little, I think, uncomfortable. There was some, like, you nausea from the anesthesia medication, but, once I was in a place where I think, you know, I was rested enough, I felt fine to get up from the bed and go home. They discharged me with instructions and for IVF retrieval these are just typical instructions I'm familiar with. You might experience some mild cramping. Some spotting is normal. And that they prescribe painkillers to take if it's too painful, but, otherwise, to take ibuprofen or Tylenol as needed. Yeah.

Q. Were you able to cook dinner that night?

A. Yes, we were. I felt well enough, and I was starving, so we stopped by one of my favorite places to have lunch there. I mean, I wasn't 100 percent there, but well enough to walk and have lunch, and then we drove home and then just took it easy. You know, I think maybe I cooked, like, a light dinner or something. Nothing, I mean, I like to cook a lot, but nothing anything fancy, just a light dinner and then probably watched a movie on the couch, which would have been very typical for us on an evening, but it wasn't anything unusual.

Q. And were you able to, two days later, move around? One day later, move around freely?

A. Oh, yeah. I mean, that day I was moving around freely. It was just, you know, you're told don't operate heavy machinery, don't drive, don't sign legal documents, all that stuff. So I didn't do any of that stuff, but, otherwise, I felt reasonably fine, yeah.

Q. Okay. When did you move to the Upper Valley?

A. June of 2015.

Q. Okay. And what was your initial DH experience in the REI division?

A. So that was, my priority was I wanted to get started on our IVF process as soon as possible, in part because, honestly, age works against women in this. So I wanted to get another cycle started. We had researched, you know, REI clinics around the area. DH made the most sense, one, for proximity purposes,

it was just convenient, but I have a history of endometriosis and adenomyosis which are uterine conditions. So my preference would have been to find a doctor who is familiar with it in the IVF context that they can provide me with the treatment that I needed. When I was looking at the profiles of different doctors, Dr. Porter, in terms of her expertise that was listed on, so I picked her and requested an initial consultation meeting with her.

Q. And did you meet with her?

A. I did, in September of 2015.

Q. Okay. When did you have your retrieval?

A. So that was a while. I met with her in September of 2015. My retrieval did not happen until over a year later in December of 2016.

Q. Okay.

A. And it was December 4th on a Sunday.

Q. Okay. Who did the retrieval?

A. Dr. Hsu.

Q. Dr. Hsu did the retrieval? What did you experience after you woke up from the retrieval?

A. Similar to my experience in Denver, the initial, you know, when you're coming out of the anesthesia, you don't remember a lot. I thought and expected that, at some point, the doctor would come to the recovery room where we're at to, again, explain, check in and explain how the procedure went to let us

know how many eggs were retrieved. That did not happen. We weren't sure what was going on.

That entire day started off oddly in the OR. At some point, we had to be discharged. So my husband had -- I had to be put in a wheelchair because I think that's the hospital policy to leave. I didn't want to leave until we had spoken to Dr. Hsu, just because I wanted to know what happened and whether we had retrieved the number of eggs we had hoped for.

I don't know how long we were waiting in the hallway, and I remember being in pain and telling my husband, like, I want to go home soon, because the crampings are getting worse, but I didn't want leave until we see the doctor. and, honestly, I don't know how long we waited. It could have been minutes. It could have been longer than. I think, to me, just because of the pain I was going through, in felt like a long time, but who knows? It could have been a shorter period than that.

And no one came to check in on us. It was just the two of us in the hallway, and, at some point, I saw him approaching us. Something was off about his body language. He wasn't, like, looking at me, even though I was in his field of vision. Sort of kind of more like shuffling. And, again, I just had this feeling something's off. Why he doesn't feel comfortable? It's almost like maybe he has bad news or something. And he moved to us and finally made eye contact, and the first thing I remember him saying is, "I'm really sorry".

That, in my head, I'm thinking, Why would a doctor start with that? I mean, are doctors even supposed to say that to patients? I mean, and it was followed by, "Looks like we only were able to retrieve one egg". That was a huge shock to me because we went in there with at least five lead follicles, and this is sort of a good indication of how many eggs you could retrieve. I had more than that. There were five lead follicles that were good in length and volume. And I think I thought I had misheard.

There was a part of me that thought, Is this, like, the anesthesia? Did he really say that? I looked at my husband. I saw his face, and, when I saw his face, I knew I didn't mishear anything because he sort of had that same look on his face. And I think, I mean, I wanted more, like, answers and follow-up, but it was sort of clear that the follow-up had ended up, and I think I also just wanted to go home.

I mentioned that I'm having some cramping, it feels a little like more cramping than I'm used to I had in the past and was told, you know, cramping is normal. Some bleeding is normal. Go home and take your, you know, take pain meds as needed, and that was it, and he walked away. And then my husband took me to our car, and we went home.

Q. What was your experience when you got home in terms of pain and symptoms?

A. So I had, I mentioned I have a history of endometriosis

and adenomyosis that causes debilitating cramping and heavy bleeding. It's common for me to just be out of commission for three to four days of the month, not being able to do anything. So my threshold, I think, for pain unfortunately is pretty high.

This was that level of cramping. It didn't feel like normal cramping and not cramping I had before in my prior retrieval. I also, the bleeding was more than spotting. I had to change -- sorry, this is, like, too much detail, but, like, I had to change pads probably every three hours or so.

And our neighbor had moved in that day, and she was having sort of an open house, come meet us, and I think, based on my past experience, I thought Oh, you know, I'm not going to go and drink and do anything, but I can least walk over, say "hi", and come back home after half an hour or so. I wasn't able to get out of bed. I was just crying and telling my husband that something, that this isn't normal. Like, this is not the normal cramping. I think something happened. I don't -- this is just my gut feeling, but something just -- I think something happened.

And, you know, obviously, I was, I don't remember anything because I was under anesthesia, but this just does not feel normal, and my body is just in so much pain. I forget how many Vicodin he had prescribed. I took the whole thing, I mean, all of it because I needed to, like, every four hours, and that's

how much pain I was in. I think on, like, day two we had considered going to the ER, but by then the pain had subsided enough where it was bearable for me, and, honestly, I didn't want to deal with going to the ER and being in the waiting room. So I decided not to.

But that day and the few days that followed, I just, it was something that I always thought of just your gut feeling, my gut feeling telling me something isn't right. I don't know what happened, but something isn't right.

Q. Okay. Did you return to Dartmouth-Hitchcock in the spring of 2017?

A. So, after the retrieval in 2016, my hope was that the transfer would be done by Dr. Porter, whenever that might be, even it meant I had to wait a while for her to come, you know, back. I was thinking maybe it would be late spring. But May of 2017 I read in the "Upper Valley News", which is a local paper --

Q. Can I interrupt you for a second? Did you, did you need surgery after? Was there a need for surgery?

ATTORNEY COFFIN: Objection, Your Honor. Approach?

THE COURT: Okay.

(Bench conference begins.)

ATTORNEY COFFIN: I'm concerned that we're going to get into a statement that she, did she need surgery, and so I just want to, before we let the cat out of the bag, get a

proffer of what's going on.

ATTORNEY NUNAN: Sure. So she, it was determined by Dr. Porter that she had Asherman's, which means, before they could do the transfer after the retrievals, she diagnosed her with Asherman's, so she needed a surgery. So it was because she needed a surgery to remove those fibroids so, if they implanted the embryo, it could actually stick. She needed a specific kind of surgery, and Dr. Porter referred her to Boston for that surgery.

ATTORNEY COFFIN: And I don't see how that has any relevance to any issues in the case at this point.

THE COURT: Okay. So you're going to ask her about, so Dr. Porter told her she needed a new surgery for something unrelated to the retrieval process?

ATTORNEY NUNAN: Well, I think where she was, she was obviously upset. You have egg retrieval. Then you have embryo transplant, but it was determined in the meantime that, before you do that transplant, you have to have this surgery to get that Asherman's taken care of so that, when we do the transplant, you have a place for the embryo to go. Otherwise, you're going miscarry again.

THE COURT: I think I'm just wondering about the implications of whether the need for that surgery is somehow going to be tied to the procedure that Dr. Hsu had done.

ATTORNEY NUNAN: It is simply the next step before

the embryo transfer, which was not successful, and that's -- like, honestly, I'm happy to move on if you feel like this is a problem. I don't see it as a problem because it's not, it has nothing to do with the egg. It's not like they have to fix anything from the egg retrieval. This was just her experience afterwards, and Dr. Porter told her to go to Boston to have that kind of surgery.

ATTORNEY COFFIN: Her experience isn't relevant to the case, except for the point that it is relevant, and the Court has ruled that the Denver surgery and what she felt there and the egg retrieval was relevant to what she experienced with Dr. Hsu. She's described what she experienced with Dr. Hsu. You know, Dr. Porter's, you know, I can't even think of the word, but that procedure doesn't have any apparently relevance to that, and where she referred her doesn't have any relevance either, because where people are being referred does not have any issue in the case.

ATTORNEY NUNAN: So what I've heard her say and, again, what I heard her say what I understood at that time is that she was trying to protect me. I thought, Wait a minute. There's no male surgeons here, and Dr. Porter clearly was shipping outside of DH to have this surgery because she couldn't do it because she was on disability. She will testify in that meeting the room was dark. She was whispering. She didn't understand what was going on with Dr. Porter, but

Dr. Porter was meeting with her as she was trying to return from her disability, and she was saying, Don't have the surgery here. Go to Boston.

ATTORNEY COFFIN: That has absolutely no relevance to impeachment or any of these things. You know, Dr. Porter interacting with her and referring her to Boston is not relevant to the whistleblower claim or the complaints about Dr. Hsu. We've allowed her to have, you know, a lot of sort of semi-expert testimony by this witness about her medical conditions and her needs, and this is going to unnecessary lengths into those things, and no notice, no nothing, and really tangentially relevant, if relevant.

THE COURT: I don't think it's semi-expert testimony, just for the record. But so it sounds like you want to get into this to kind of complete the narrative, but you also don't need to get into it to establish what you had said a moment ago.

ATTORNEY NUNAN: I'll take instruction. I would like to get this out. This is her experience. I think she needs to say it.

THE COURT: But are you saying the ultimate kind of point of this is that Dr. Porter recommended that she go to Boston for what reason now?

ATTORNEY NUNAN: So she needed a surgery that Dr. --

THE COURT: Right. I got that, but I thought you

were kind of suggesting that there was some issue at Dartmouth that she was seeking to have her avoid.

ATTORNEY NUNAN: What she told me when I interviewed her was, I didn't understand at the time, but I understood later that Dr. Porter, by referring me out, was saying she was trying protect me.

THE COURT: From?

ATTORNEY NUNAN: From the harm of going under the surgery with Dr. Hsu again. The other option was to have Dr. Hsu do the surgery, and what she understood was Dr. Hsu, that Dr. Porter was telling her, Go somewhere else. She didn't say that, but she said afterwards, I realized at the time I was thinking, Why would I go to Boston when you have somebody here who can to this? Anyway.

ATTORNEY COFFIN: This is enormously prejudicial without the normal basis in medical expertise and medical records and things like that. This is like story, legend telling from a witness based on the personal experience on something that really she doesn't have the expertise on with zero notice to us.

THE COURT: All right. So don't go into that area, and, if you could ask her, please, to lean into the microphone, I'm having a very hard time.

ATTORNEY NUNAN: Sure, that's fair. Okay.

(Bench conference ends.)

BY ATTORNEY NUNAN:

Q. Eunice, could I get you to speak into the microphone?

A. Oh, yeah. Sure.

Q. Not a problem. Eventually, did you go to UVM to get further IVF care?

A. After the REI clinic closed down, yeah.

Q. Okay. And who did you see at UVM?

A. So the first physician I saw was Joseph Findlay, and then, at some point, Dr. Porter joined UVM, and then she became involved with my care. So the two of them were my primary doctors.

Q. Did you have an egg harvest and embryo transfer at UVM?

A. I did, Two cycles, one in 2018 and then another one in 2019.

Q. And can you just tell me the experience coming out of your egg retrieval at UVM?

A. It was more similar to my Denver experience in that, you know, when I was coming out of the anesthesia, at some point, my husband came back to join me, and then Dr. Porter or Dr. Findlay or both came to let me know how it went and how many eggs were retrieved and just to check in to see how I was doing and to, you know, tell me to take it easy, and yeah.

Q. Were you able to move around?

A. Um-hum. Yeah.

Q. Were you able to get pregnant?

A. The 2018 one, I was, and we had implanted or transferred, sorry, three eggs or embryos, including the one that came from DH.
Q. Ultimately, were you able to carry that to the end?
A. No.
Q. Did you have to have a procedure with Dr. Porter, eventually?
A. Yes. Um-hum.
Q. Okay. What was that procedure?
A. So, at the end of 2019 when I did my last transfer or IVF cycle, I mean, thereafter, Covid happened, honestly, and kind of gave me pause to think of, What I have gone through, what I was willing to go through. And I just decided that I had done everything I could possibly do and that that my body just, it couldn't give anymore. And I, you know, for me, I just wanted to be a mom.

So I went looking into adoption, but, because of my history with endometriosis and adenomyosis and the pain that it causes, I didn't want it to affect my ability to care for my baby if we end up matching. And hysterectomy was the, really the only option for me, and I wanted, asked Dr. Porter if she would be willing to do the surgery for me because I wanted the best care and the care of somebody who I trust and has followed, you know, me from the beginning of this. And I, you know, shared with her my main reason, that I was ready to move

on and just want to be a mom in the healthiest, best way possible, and she supported me and just said, "If you're ready, I'm here. Let's do this". And --

Q. This story has a very happy ending, right?

A. Yeah.

Q. Okay. Tell me about that.

A. So my surgery was in August, and it was, I mean, I shouldn't -- it's weird to say the surgery was so great because it was a medical procedure, but there was just so much, like, warmth and care in the room. The last thing I remember Dr. Porter telling me is to say, "Let's take care of you. Let's get you a baby". And then exactly a week later we matched with a birth mom.

Q. And that birth mom had how many babies?

A. Two, so I have twins.

Q. Great.

A. Yeah.

Q. That's great. Okay.

A. Yeah.

Q. This is clearly a very painful experience for you to come into public and tell. Why did you want to do it?

A. When I read about the news, the lawsuit and what had been going on at DH, there was several things that I felt. One was relief in knowing that, okay, this wasn't in my head, and, for a while, I had been carrying with me that I had done something,

that this had been my fault. For that part, I just, I had a sense of relief that okay.

Q. When you read the story, what was your reaction?

A. I felt sick to my stomach, and I actually didn't finish reading. I read enough to know that, okay, this wasn't in my head, that gut feeling that I had this entire time, and, like, that day that I'd been reliving over and over again, that there was, like, truth and validity to it. So, for me, there was a sense of relief as I kind of let that go because I'd been carrying it with me.

Another part of it was I can't imagine just feeling, you know, awful for Dr. Porter about what, not -- I had no idea what was going on and what she had been going through.

And but the third part, and maybe this is, like, the most important part for me, is I kept thinking, What about us? Like, what about the patient? I can't be the only woman who is finding about it this way and the only woman who, for years, has been wondering, Did I do something wrong, and was this my fault? And not knowing what. And it just, I had, like, anger and disappointment and sadness, and I didn't want us just to be these nameless patients out of, like, a billing statement. Because this is so personal to me, and, if this is what it's doing to me ten years later, I can't imagine what other women are going through, and I kept thinking there has to be a face to this. And a person was assigned to this that, that this is

what it has caused, and the pain is still here and just as raw after ten years.

Q. Okay, okay.

A. Sorry.

Q. It's okay. I really appreciate you being here. I think we should probably stop.

A. I'm sorry.

ATTORNEY NUNAN: Don't be sorry. No further questions.

THE COURT: Mr. Coffin.

ATTORNEY COFFIN: If I may have a moment, Your Honor?

THE COURT: Yes.

CROSS-EXAMINATION BY ATTORNEY COFFIN

Q. Good afternoon, Ms. Lee.

A. Hi.

Q. I'm Tris Coffin. I'm a lawyer for Dartmouth-Hitchcock. How are you today, hanging in there?

A. Hanging in there, yeah.

Q. You might recall I called and left a message at your law office.

A. Yes, I do remember.

Q. A couple of weeks ago. Time has gone by quickly. Anyway, good to see you today. And I don't have many questions for you, but I just have a couple. Thank you for coming in and sharing your experience. Obviously, very heartfelt, and I just

want to say, by the way congratulations on your family situation. That's wonderful.
A. Thank you. They're wonderful.
Q. You saw Dr. Hsu that one time; is that right?
A. Um-hum. Yes.
Q. And he didn't come out and deal with you very effectively as a doctor; is that right?
A. Correct.
Q. And then you went home, and you had some pain, correct?
A. Correct.
Q. And the prior surgery or egg retrieval when you were in Denver, you had some pain from that as well?
A. Yes, mild cramping, I would say.
Q. But this was significantly worse?
A. Yes.
Q. And you took some Vicodin to take care of that that had been prescribed for you, correct?
A. Yes.
Q. And you thought about going to the emergency room the next day, but the pain had subsided by then; is that correct?
A. Correct.
Q. And, with regard to Dr. Hsu, I take it from your experience with Dr. Porter and Dr. Hsu and the Denver doctors that your experience with him was different; is that right?
A. Yes.

Q. And, in your view as an attorney and a patient, appropriate to have some follow-up by a supervisor of Dr. Hsu to remedy that kind of, type of approach with a patient, fair to say?
A. Could you say that again? Sorry.
Q. You know, wouldn't you agree that it would be reasonable for there to be some follow-up with Dr. Hsu about how he conducts himself with patients based on your experience that one time, right?
A. Yeah. I mean, in general, I just thought we have the retrieval and then, at some point, there's a follow-up appointment of sort where we go over, you know, numbers, what went wrong, or that kind of thing.
Q. Yeah. My question is slightly different that, if there was a doctor who had problems interacting with patients and providing care that they needed in an appropriate and effective way, you'd expect that to be the subject of some concern by the institution; is that right?
A. Yes.
Q. And so, if there was follow-up attempts to mentor, training, that would be in line with that, right?
A. In line with correcting his behavior, you mean?
Q. Yeah.
A. Yeah, I think so.
Q. Yeah, right. Okay. And, if the behavior wasn't

corrected, even up to possibly terminating the physician might be a reasonable thing to do; isn't that right?

A. I mean, I would think, if there was an issue with a physician and there is attempts correct whatever issue there is that can't be remedied by training or whatever follow-up, it would be very reasonable to expect to terminate that physician. I mean, again, I don't practice medicine. I'm not sure, but, logically, that seems to be reasonable.

Q. Okay.

A. Yeah.

ATTORNEY COFFIN: Those are all the questions I have. Thank you again for coming in here, and congratulations.

THE WITNESS: Thank you.

THE COURT: Ms. Nunan, any further questions?

ATTORNEY NUNAN: No further questions.

THE COURT: Okay. Ms. Lee, you may step down. Okay. And does that conclude the plaintiff's rebuttal case?

ATTORNEY JONES: It does, Your Honor. Thank you.

THE COURT: Okay. So, members of the jury, that means the evidence is now closed in the case. There will be no further presentation of evidence, so I'll kind of explain the process to you from here. So, as you may recall from when we first met and I gave you preliminary instructions, I told you that the final stage of a trial is the closing arguments by the attorneys. That is the next stage, and, in this case, that

will not be happening today. The attorneys will be delivering their closing arguments to you on Tuesday morning, which means then the remainder of this afternoon you will be off, and we will not be meeting on Monday, okay? So you'll return to court on Tuesday to get going again at 9:00 a.m.

After the attorneys present their closing arguments to you on Tuesday, then I'll be instructing you on the law, and, at that point, you will officially then get the case, and you will retire then to the deliberations room, jury room, for your deliberations, and that's, that's what you can expect next, okay?

So, at this time, I will excuse you. Have a good weekend, and we will see you Tuesday at 9:00. The usual admonition, please don't talk to anyone or to your fellow jurors about the case or do any independent research on the case between now and Tuesday. Thank you.

(The Jury leaves the courtroom.)

THE COURT: Okay. So, just in terms of jury instructions, charge conference, Emerson will email all of the attorneys copies of the Court's jury instructions Monday morning. I think I mentioned this to you yesterday. You will have the morning and some of the afternoon to review this, and then we'll meet at 1:00 o'clock. I think the best thing to advise is you can come here to the courtroom and Emerson can take you upstairs. I'm anticipating that we'll do the charge

conference either in my chambers or in the jury room on the fourth floor. It all depends on how many people are coming. I think, if the past is any indication, everyone's coming. So it might make sense then for us to do it in the jury room. There was a knock on the door, so I'll just pause here for a moment.

(Brief pause.)

All right. So that was all I was going to tell you. So you'll get the jury instructions Monday morning. You can come here a few minutes before 1:00. Emerson can escort the group to the fourth floor to where we're going to meet, and, as I said, that will be at 1:00 o'clock, okay?

Anything from the parties at this time?

ATTORNEY JONES: Nothing for the plaintiff.

ATTORNEY SCHROEDER: Nothing for the defendants.

THE COURT: Okay. Enjoy your weekends.

(Whereupon at 1:36 p.m. the hearing was adjourned.)

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C E R T I F I C A T E

I, Sunnie Donath, RMR, Official Court Reporter for the United States District Court, District of Vermont, do hereby certify that the foregoing pages are a true and accurate transcription of my stenographic notes of the hearing taken before me in the above-titled matter on April 4, 2025 to the best of my skill and ability.

Sunnie Donath, RMR

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Sunnie Donath, RMR